

UNICARE STATE INDEMNITY PLAN MEDICARE EXTENSION

Member Handbook for Medicare Retirees
participating in the Retired Municipal Teacher Program
and the Elderly Governmental Retiree Program

Effective July 1, 2016

UNICARE STATE INDEMNITY PLAN
MEDICARE EXTENSION
MEMBER HANDBOOK

**For Medicare retirees participating in the
Retired Municipal Teacher Program and the
Elderly Governmental Retiree Program**

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.

For a translation of the above text, see Appendix C.

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)
TDD¹: 800-322-9161
contact.us@anthem.com
unicarestatement.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

SilverScript

877-876-7214 (toll free)
TDD¹: 800-238-0756
gic.silverscript.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)
TDD¹: 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 89 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 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 insured and administered by the UniCare State Indemnity Plan.

1: Getting started with Medicare Extension	12
About your Medicare Part A and Part B membership	12
Introducing your medical plan	12
Prescription drugs and behavioral health	13
Do you have benefits under another health plan?	13
Using this handbook.....	13
What the handbook symbols mean.....	13
About your ID cards.....	14
When you must provide notice about your care.....	14
List of notification requirements	15
2: What to know about costs.....	16
What member costs are	16
How member costs work.....	16
About your deductible.....	16
About copays.....	17
About coinsurance.....	17
About the out-of-pocket limit.....	18
How Medicare and Medicare Extension work together.....	18
About allowed amounts and Medicare-approved amounts.....	19
About balance billing	19
How the providers you use can affect your costs.....	20
About preferred vendors.....	21
3: Find out what's covered.....	22
Summary of benefits	22
Ambulance services.....	27
Anesthesia	27
Autism spectrum disorders.....	27

Behavioral health services	27
Cardiac rehabilitation programs.....	28
Chemotherapy.....	28
Chiropractic care.....	28
Circumcision.....	28
Cleft lip and cleft palate for children under 18.....	29
Clinical trials (clinical research studies).....	29
Dental services.....	30
Diabetes care.....	31
Diabetes supplies	32
Dialysis	33
Doctor and other health care provider services.....	33
Durable medical equipment (DME).....	33
Early intervention programs for children.....	35
Emergency room.....	35
Enteral therapy	36
Eye care.....	36
Eyeglasses and contact lenses.....	37
Family planning and hormone replacement.....	37
Fitness club reimbursement	38
Foot care (routine).....	38
Formulas (special).....	39
Gynecology exams.....	39
Hearing aids	39
Hearing exams	40
Home health care	40
Home infusion therapy.....	41
Hospice care.....	42
Infertility treatment.....	43
Inpatient care at hospitals.....	44
Inpatient care at other facilities.....	47
Laboratory and radiology services.....	48
Maternity services.....	48
Medical clinics (non-hospital-owned)	48
Medical services (not otherwise specified).....	49
Nutritional counseling.....	49
Occupational therapy	49
Outpatient hospital services	50
Oxygen.....	50
Palliative care.....	50
Personal Emergency Response Systems (PERS).....	51
Physical therapy (manipulative therapy)	51
Prescription drugs	52
Preventive care.....	52

Private duty nursing	52
Prosthetics and orthotics.....	53
Radiation therapy	53
Sleep studies	54
Speech therapy	54
Surgery	54
Tobacco cessation counseling	56
Transplants	57
Travel clinics	58
Wigs	58
Schedule of preventive care services.....	59
4: Coverage that is excluded or limited	63
5: About your plan and coverage	70
How to use your plan wisely	70
Types of health care providers	71
How to find providers	72
How UniCare reimburses providers	72
How claims are processed	72
How to submit a claim	72
Deadlines for filing claims	73
About claim reviews.....	73
Deadlines on bringing legal action	73
Right of reimbursement.....	73
About your privacy rights	74
About your appeal rights	74
Involuntary disenrollment rate	74
Reporting requirements	74
How medical services get reviewed	74
Getting support for serious medical issues.....	75
6: About enrollment and membership.....	76
Free or low-cost health coverage for children and families	76
Eligibility for benefits	76
Application for coverage	76
When coverage begins	76
When coverage ends for enrollees	77
When coverage ends for dependents	77
Disenrollment	77
Continuation of coverage for Massachusetts residents	78
Duplicate coverage	78
Special enrollment condition.....	78
Continuing coverage	78

Group health continuation coverage under COBRA 80
 Coordination of Benefits (COB) 84

7: How to get more information 87
 Who to contact (and for what) 87
 Contacting the UniCare Customer Service Center 88
 Using the unicarestatement.com website 88
 Using the 24/7 NurseLine 89
 How to ask for a claim review 90
 How to check on your claims 90
 How to ask to have medical information released 90
 The Patients’ Bill of Rights and Office of Patient Protection 90

8: Definitions 91

Part 2: Prescription Drug Plan 97

Describes the benefits for prescription drugs. These benefits are administered by SilverScript.

Section I – Introduction 98
 Things to Know About SilverScript 99
 Section II – Summary of Benefits 101
 Multi-Language Insert 105

Part 3: Behavioral Health Plan 107

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 108
 How to Contact Beacon Health Options 108
 How to Get Optimal Benefits 108
 Referral/Prior Authorization for EAP and Non-Routine Services 109
 Emergency Care 109
 Urgent Care 110
 Routine Care 110
 Confidentiality 110
 Coordination of Benefits 110

Part II – Benefits 111
 Benefits Explained 111
 What This Plan Pays: Summary of Covered Services 115
 Covered Services 118
 Enrollee Assistance Program (EAP) 121

Case Management	122
What’s Not Covered – Exclusions	123
Part III – Definitions, Appeals, Complaints and Grievances	126
Definitions of Beacon Health Options Behavioral Health Terms	126
Filing Claims	128
Complaints	128
Appeals	129
Appendices	133
Appendix A: GIC Notices	134
Important Notice from the GIC about Your Prescription Drug Coverage and Medicare	134
The Uniformed Services Employment and Reemployment Rights Act (USERRA)	136
Appendix B: Privacy Notices	137
UniCare’s HIPAA Notice of Privacy Practices	137
Maine Notice of Additional Privacy Rights	141
Appendix C: Interpreting and Translating Services	142
Appendix D: Forms	144
Fitness Club Reimbursement Form	145
Appendix E: Federal and State Mandates	146
Premium Assistance under Medicaid and the Children’s Health Insurance Program (CHIP)	146
Coverage for Reconstructive Breast Surgery	149
Minimum Maternity Confinement Benefits	149
Appendix F: Your Right to Appeal	150
Inquiry Process	150
Grievances/Appeals Process	150
Time Requirements for Resolution of Grievances/Appeals	151
Expedited Grievance/Appeal Process	152
How to File an Inquiry, Complaint or Grievance/Appeal	153
External Review Process	154
Expedited External Review Process	154
Index	155

List of Tables

Table 1.	Notification Requirements	15
Table 2.	Deductible Amounts	16
Table 3.	Copays for Medical Services	17
Table 4.	The CIC Out-of-Pocket Limit on Coinsurance	18
Table 5.	How Medicare-Provider Arrangements Affect Benefits	20
Table 6.	Summary of Covered Services.....	22
Table 7.	Preventive Care Schedule	59
Table 8.	How Medicare Part D Stages Work.....	101
Table 9.	Mental Health, Substance Use Disorder, and EAP Benefits for Medicare Members	113
Table 10.	Summary of Covered Services.....	115

PART 1: YOUR MEDICAL PLAN

Description of Benefits

This is the Certificate of Insurance for Elderly Governmental Retirees and Retired Municipal Teachers who **are** eligible for Medicare. Coverage is provided under Group Policy Number GI 131192, under which UniCare Life & Health Insurance Company is the insurer and the Group Insurance Commission of the Commonwealth of Massachusetts is the plan sponsor.

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



1: Getting started with Medicare Extension

This handbook is a guide to benefits for you and your Medicare dependents covered under UniCare State Indemnity Plan/Medicare Extension. These benefits are provided under Group Insurance Policy GI 131192, insured by UniCare Life and Health Insurance Company. The Group Insurance Commission (GIC) of the Commonwealth of Massachusetts is the plan sponsor.

This handbook is not a description of your Medicare benefits. For more information about Medicare, read the *Medicare & You* handbook, which is produced by Medicare and is available from your local Social Security office, or online at medicare.gov.

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.

About your Medicare Part A and Part B membership

 **You must be enrolled in Medicare Part A and Part B to be eligible for the Medicare Extension plan. If you let your Medicare coverage lapse, you will no longer be eligible for benefits under the Medicare Extension plan.**

Introducing your medical plan

UniCare State Indemnity Plan/Medicare Extension supplements your Medicare coverage by providing you with comprehensive coverage 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. Keep in mind, however, that benefits differ depending on the service and the provider, and that not all services are covered by the Plan.

The Plan provides all health care services and benefits you are entitled to on a nondiscriminatory basis, including benefits mandated by state or federal law.

UniCare State Indemnity Plan/Medicare Extension does not exclude pre-existing conditions.

The Plan provides you with freedom of choice in selecting your physicians, including coverage for pediatric medical specialty. The Plan will provide coverage for pediatric specialty care, including mental health care, to individuals requiring such services.

Part 1 of this handbook (pages 11-95) describes your coverage for medical services, and provides information about two different medical plan designs:

- 1. The Medicare Extension plan *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. The Medicare Extension plan *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 **SilverScript**. These benefits are described in Part 2 of this handbook (pages 97-106).
- ❑ Your **behavioral health benefits** are insured 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 107-131). You can also call Beacon toll free at 855-750-8980 for details about your coverage.

For additional information about practicing physicians in Massachusetts, contact the Massachusetts Board of Registration in Medicine at 800-377-0550 or via their website at massmedboard.org.

Do you have benefits under another health plan?

If you or a family member is covered under another health plan (with the exception of Medicare or TRICARE), 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 84.

Remember: You don't need to notify UniCare if you have Medicare or TRICARE coverage.

Using this handbook

Throughout this handbook, UniCare State Indemnity Plan/Medicare Extension is referred to by its full name, or as the UniCare State Indemnity Plan, the Medicare Extension 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.
-  **Use Medicare contract suppliers or UniCare preferred vendors** – To get the best benefit, use a Medicare contract supplier or UniCare preferred vendor for this service or product. See page 21 to learn more.
-  **Check the website** – Information about this topic can be found at unicarestatplan.com.

About your ID cards

You will get a UniCare ID card when you enroll in the Medicare Extension plan. When you need health care services, tell your provider that you are a member of both Medicare **and** the Medicare Extension plan. Show your provider both your Medicare card and your UniCare ID card.

Your ID card has useful information about your benefits, as well as important telephone numbers you and your health care providers may need.

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

When you must provide notice about your care

Under some circumstances, you or your provider must tell UniCare about certain medical services you get. UniCare reviews these services 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 74.

You must notify UniCare 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 page 15 lists all the services that require notice and how far in advance you must provide notice (for example, one business day or seven calendar days before the service takes place).

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.

If you're not sure whether notice is required

If you're not sure whether you must notify UniCare, 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. You must notify UniCare *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.

List of notification requirements

You must notify UniCare Customer Service at 800-442-9300 within the specified amount of time for the services listed in Table 1. Note that some of the listed services may be performed in a doctor's office.

Table 1.  Notification Requirements

Treatment or service	Notice required
Emergency admission	Within 24 hours (next business day)
Maternity admission	Within 24 hours (next business day)
Non-emergency admission	At least 7 calendar days before admission For elective inpatient treatment
Organ transplants	At least 21 calendar days before services start You don't need to provide notice for cornea transplants.
Gender reassignment surgery	At least 21 calendar days before services start
 Durable medical equipment (DME)	At least 1 business day before ordering the 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.
 Enteral therapy	At least 1 business day before the services start if Medicare is not going to cover the services
 Home health care	At least 1 business day before the services start if Medicare is not going to cover the services Services must be provided by one of the following: <ul style="list-style-type: none"> ▪ Home health agency ▪ Visiting nurse association
Private duty nursing	At least 1 business day before the services start

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:

- ❑ Your **deductible** (page 16)
- ❑ **Copays** or **copayments** (page 17)
- ❑ **Coinsurance** (page 17)

How member costs work

Because you are in the Medicare Extension plan, Medicare pays its portion of your claims first. Once the Medicare portion of a bill is paid, the remainder of the claim balance is sent to UniCare.

When UniCare gets the bill, your member costs are subtracted from the amount we pay to your provider. Any member costs that apply are subtracted as follows: the copay gets subtracted first, then the deductible, and lastly any coinsurance. We'll send you an *Explanation of Benefits* (EOB) statement that shows you how the claim was paid.

After receiving payment from UniCare, your provider will send you a bill for the amount of your member costs; that is, the amount UniCare initially 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 many medical services each calendar year before UniCare starts paying benefits for those services. Your deductible starts on January 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 must pay your deductible before physical therapy will be covered, but not laboratory tests. Physical therapy is *subject to the deductible*, but laboratory tests are not. Chapter 3 shows which services are subject to the deductible.

As Table 2 shows, the amount of your deductible depends on whether or not you have CIC coverage.

Table 2. Deductible Amounts

	With CIC (Comprehensive Insurance Coverage)	Without CIC (Non-Comprehensive Insurance Coverage)
Deductible amount	\$35	\$100

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 get an eye exam, or when you go to the emergency room. The dollar amount of your copay depends on the service you're getting. Table 3 lists the copays in the Medicare Extension plan.

Table 3. Copays for Medical Services

	With CIC (Comprehensive Insurance Coverage)	Without CIC (Non-Comprehensive Insurance Coverage)
Office visits	None	None
Routine eye exams	\$10 per visit	\$10 per visit
Emergency room	\$25 per visit (waived if admitted)	\$25 per visit (waived if admitted)
Inpatient hospital care	\$50 per quarter	\$100 per quarter

Copays can work in two different ways:

- ❑ **Per-visit copays** – You pay per-visit copays every time you have that service. As Table 3 shows, you pay a per-visit copay for eye exams and emergency room visits.
- ❑ **Quarterly copays** – You pay quarterly copays only once each calendar quarter, no matter how many times you get that service during the quarter. The copay for inpatient hospital services is a quarterly copay.

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. You will owe this copay each time you or your covered dependent is admitted to a hospital. However, once you pay this copay, you won't have to pay it again for this person during the same calendar quarter. As is true of all member costs, this copay is applied to any balance that remains after Medicare processes your claim.

Example – You are admitted to a hospital in January and stay overnight, so you owe a copay for the claim balance that remains after Medicare's payment. If you are readmitted to a hospital in March, you won't owe another copay, because March is in the same calendar quarter. But if you are readmitted to a hospital in May, you will have to pay the quarterly copay again.

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

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%. As is true of all member costs, coinsurance is applied to any balance that remains after Medicare processes your claim. Chapter 3 shows which services have coinsurance.

About the out-of-pocket limit

To protect you from large medical expenses, the Medicare Extension plan with CIC limits the coinsurance you could pay each calendar year toward covered services. Once you reach this **out-of-pocket limit**, the Plan pays 100% of the allowed amount for covered services for the rest of the year. (To learn more about allowed amounts, see “About allowed amounts and Medicare-approved amounts” on page 19).

Table 4. The CIC Out-of-Pocket Limit on Coinsurance

	With CIC (Comprehensive Insurance Coverage)	Without CIC (Non-Comprehensive Insurance Coverage)
Out-of-pocket limit on coinsurance	\$500 limit	No limit

Deductibles, copays, charges over the allowed amount, charges for non-covered services, and certain coinsurance amounts don't count toward the CIC out-of-pocket limit. Chapter 3 shows which coinsurance costs apply to the CIC out-of-pocket limit.

If you don't have CIC coverage, there is no limit on the coinsurance you could pay.

How Medicare and Medicare Extension work together

What the Medicare Extension plan covers

Medicare Extension covers all or part of any costs that Medicare does not pay for covered services. For example, if Medicare pays 80% of a claim, the Plan will pay some or all of the remaining 20%. The Plan also covers the Medicare Part A inpatient deductible, the Part B deductible, and Part B coinsurance.

Keep in mind... Medicare Part A provides benefits for hospital services, and Part B provides benefits for physician and other health care provider services.

Medicare Extension provides coverage for some services that Medicare doesn't cover, such as immunizations and hearing aids. There are also some services that Medicare covers but Medicare Extension does not. See Chapter 4 to find out which services are not covered or have limited coverage.

How benefits are determined between Medicare and Medicare Extension

When you submit a claim, UniCare determines your benefits as follows:

1. The claim is eligible for payment only if it is for a covered service under Medicare and/or the Medicare Extension plan.
2. The maximum amount that may be paid is either the Plan's allowed amount or the Medicare-approved amount, whichever is less (see the next topic).
3. UniCare subtracts any benefits that Medicare has paid from the original amount of the claim.
4. Medicare Extension benefits are applied to any remaining claim balance.

About allowed amounts and Medicare-approved amounts

Medicare sets an allowed cost – the **Medicare-approved amount** – for each service that it covers, and makes payments based on that amount. So, for example, if Medicare covers 80% of a service, it will pay up to 80% of the Medicare-approved amount for that service.

UniCare sets an **allowed amount** for each service that it covers. The allowed amount is the maximum amount that UniCare pays for a covered service.

UniCare uses several methods to determine allowed amounts. An allowed amount may be the same as the Medicare-approved amount, or it may be an amount within the range of payments most often made to similar providers for the same service or supply. Allowed amounts are shown as maximum fees in fee schedules, maximum daily rates, flat amounts or discounts from charges.

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, it is called **balance billing**.

By law, Massachusetts providers aren't allowed to balance bill you. However, providers in other states may do so. The Plan doesn't cover balance bills, and balance bills don't count toward the CIC out-of-pocket limit on coinsurance (page 18).

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.

When you get care outside of Massachusetts

Providers outside of Massachusetts are free to balance bill you 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.

To reduce your risk of being balance billed, we recommend always using Medicare participating providers. See the next topic to learn how a provider's payment arrangement with Medicare can affect your costs.

How the providers you use can affect your costs

Providers can have several different payment arrangements with Medicare. These arrangements determine how much Medicare pays the providers and what costs you will have to pay yourself.

- ❑ **Enrolled providers** agree to do business with Medicare and accept Medicare payment. Medicare will only pay for services from enrolled providers. Enrolled providers have two different payment arrangements:
 1. **Medicare participating providers** are enrolled providers who have signed an agreement to accept Medicare assignment; that is, they agree to accept Medicare’s payment as payment in full for covered services. Medicare contract suppliers are participating providers (see page 21).
 2. **Non-participating providers** are enrolled providers who have not agreed to accept Medicare assignment. They may charge more than the Medicare-approved amount (within certain limits), and you are responsible for the additional cost.
 - ❑ **Un-enrolled providers (private contracts)** don’t do any business with Medicare at all. Medicare won’t pay for services from these providers, even if the service would otherwise be covered. Un-enrolled providers are required to have you sign a private contract to confirm that you will pay for the services yourself.
-  **Important!** If you go to an un-enrolled provider for a service that Medicare would otherwise cover, the Medicare Extension plan covers only 20% of what Medicare would have paid to an enrolled provider. You must pay the rest of the cost yourself.

For more information – See your *Medicare & You* handbook (available at medicare.gov) and other Medicare publications for additional information about how Medicare pays providers.

Table 5 illustrates how your benefits work for the three types of providers.

Table 5. How Medicare-Provider Arrangements Affect Benefits

Type of provider	Claim amount	Allowed amount ¹	Medicare pays	UniCare pays	You owe
Participating provider (including Medicare contract suppliers)	\$150	\$100	\$80	\$20	\$0
Non-participating provider	\$150	\$100	\$80	\$20	\$50 ²
Un-enrolled provider (private contract)	\$150	\$100	\$0	\$20 ³	\$130 ⁴

1. Either the Medicare-approved amount or UniCare’s allowed amount
2. The amount of the claim left over after Medicare and Medicare Extension have paid
3. UniCare pays only what it would have paid if you had used a participating provider
4. The amount of the claim that neither Medicare nor UniCare paid

About preferred vendors

For certain services and supplies, you get the highest benefit when you use a preferred vendor.

Preferred vendors are vendors who have contracted with Medicare, UniCare or both to provide one or more of the following services and supplies:

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

For any of these items that are included in Medicare's DMEPOS Competitive Bidding Program, the preferred vendors are Medicare contract suppliers.

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

When to use Medicare contract suppliers

Certain durable medical equipment, prosthetics, orthotics, and other supplies are available from **Medicare contract suppliers**. Medicare contract suppliers are vendors who were chosen by Medicare's Competitive Bidding Program to provide these items to Medicare members.

Your costs are covered at 100% of the allowed amount when you get covered items from a Medicare contract supplier. (Note that your deductible may also apply.) If a Medicare contract supplier is available to use, claims from non-contract suppliers are not covered by either Medicare or UniCare.

 Go to medicare.gov/supplier to learn about Medicare's DMEPOS Competitive Bidding Program and to find a contract supplier in your area.

On occasion, there may not be a Medicare contract supplier available where you live. If that happens, use a UniCare preferred vendor for the best coverage (see the next topic).

When to use UniCare preferred vendors

When a Medicare contract supplier isn't available, use a UniCare preferred vendor to get the best benefit. UniCare preferred vendors have contracted with UniCare to provide one or more of the services and supplies listed above. Services from these vendors are covered at 100% of the allowed amount.

Non-preferred vendors are covered at 80% and you will owe the remaining 20% coinsurance. This is true even if you are using a non-preferred vendor because the item or service isn't available from a preferred vendor. 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.

 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!** Medicare contract suppliers, when available, are the preferred vendors. Use a UniCare preferred vendor if there is no Medicare contract supplier available.

3: Find out what's covered

Summary of benefits

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

Table 6. Summary of Covered Services

	With CIC	Without CIC	See page
Ambulance services	\$35 deductible, then 100%	100% of the first \$25	27
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.		107
Cardiac rehabilitation programs	100%	100%	28
Chemotherapy	\$35 deductible, then 100%	\$100 deductible, then 80%	28
Chiropractic care	\$35 deductible, then 80%, up to a limit of 20 visits each calendar year	\$100 deductible, then 80%, up to a limit of 20 visits each calendar year	28
 Diabetes supplies <i>See page 21 for important information about Medicare contract suppliers and UniCare preferred vendors.</i>	From preferred vendors: \$35 deductible, then 100% From non-preferred vendors: \$35 deductible, then 80%	From preferred vendors: \$100 deductible, then 100% From non-preferred vendors: \$100 deductible, then 80%	32
Dialysis	\$35 deductible, then 100%	\$100 deductible, then 80%	33
Doctor and other health care provider services			33
▪ Office visits	\$35 deductible, then 100%	\$100 deductible, then 100%	
▪ Inpatient hospital	100%	100%	
▪ Emergency room treatment	100%	100%	
  Durable medical equipment (DME) <i>See page 21 for important information about Medicare contract suppliers and UniCare preferred vendors.</i>	From preferred vendors: \$35 deductible, then 100% From non-preferred vendors: \$35 deductible, then 80%	From preferred vendors: \$100 deductible, then 100% From non-preferred vendors: \$100 deductible, then 80%	33

All services must be medically necessary and all charges are subject to the Plan's allowed amount for that service (page 19).

Table 6. Summary of Covered Services (continued)

	With CIC	Without CIC	See page
Early intervention programs	100%	100%	35
Emergency room	\$25 copay, then 100%	\$25 copay, then 100%	35
Eye care (routine)	\$10 copay, then 100%; covered once every 24 months	\$10 copay, then 100%; covered once every 24 months	36
Eyeglasses and contact lenses	100%; limited to the initial lenses within six months after an eye injury or cataract surgery	80%; limited to the initial lenses within six months after an eye injury or cataract surgery	37
Family planning and hormone replacement	100%	100%	37
Fitness club reimbursement	\$100 per family each calendar year	\$100 per family each calendar year	38
Hearing aids			39
▪ 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	\$35 deductible, then 100% of the first \$500, then 80% of the next \$1,500, up to a limit of \$1,700 every 24 months	\$100 deductible, then 100% of the first \$500, then 80% of the next \$1,500, up to a limit of \$1,700 every 24 months	
Hearing exams	\$35 deductible, then 100%	\$100 deductible, then 100%	40
  Home health care	From preferred vendors: \$35 deductible, then 100% From non-preferred vendors: \$35 deductible, then 80%	From preferred vendors: \$100 deductible, then 100% From non-preferred vendors: \$100 deductible, then 80%	40
 Home infusion therapy	From preferred vendors: \$35 deductible, then 100% From non-preferred vendors: \$35 deductible, then 80%	From preferred vendors: \$100 deductible, then 100% From non-preferred vendors: \$100 deductible, then 80%	41
Hospice care	\$35 deductible, then 100%	\$100 deductible, then 100%	42
▪ Bereavement counseling	\$35 deductible, then 80%, up to \$1,500 per family	\$100 deductible, then 80%, up to \$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 19).

Table 6. Summary of Covered Services (continued)

	With CIC	Without CIC	See page
Inpatient care at hospitals			44
<ul style="list-style-type: none"> Semi-private room, ICU, CCU, and ancillary services 	\$50 quarterly copay, then 100%	\$100 quarterly copay, then 100%	
<ul style="list-style-type: none"> Private room (if medically necessary) 	\$50 quarterly copay, then 100% of the semi-private room rate	\$100 quarterly copay, then 100% of the semi-private room rate	
Inpatient care at other facilities, including:			47
<ul style="list-style-type: none"> Chronic disease hospitals / facilities Long-term care hospitals / facilities Skilled nursing facilities Sub-acute care hospitals / facilities Transitional care hospitals / facilities 	<p>For days paid by Medicare: \$35 deductible, then 100% of your Part A deductible and coinsurance for up to 100 days; then 80% for the rest of the year, up to a limit of \$10,000 each calendar year</p> <p>For days not paid by Medicare: 80%, up to a limit of \$10,000 each calendar year</p>	<p>For days paid by Medicare: \$100 deductible, then 100% of your Part A deductible and coinsurance for up to 100 days; then 80% for the rest of the year, up to a limit of \$7,500 each calendar year</p> <p>For days not paid by Medicare: 80%, up to a limit of \$7,500 each calendar year</p>	
Laboratory and radiology services (X-rays)			48
<ul style="list-style-type: none"> Inpatient / emergency room 	100%	100%	
<ul style="list-style-type: none"> Outpatient and non-emergency 	100%	80%	
Medical clinics (non-hospital-owned) Including urgent care centers and retail clinics	\$35 deductible, then 100%	\$100 deductible, then 80%	48
Medical services (not otherwise specified)	Deductible, then 80%	Deductible, then 80%	49
Occupational therapy	<p>If Medicare pays: 100% of your Part B deductible and coinsurance</p> <p>If Medicare does not pay: \$35 deductible, then 80%</p>	\$100 deductible, then 80%	49
Office visits	\$35 deductible, then 100%	\$100 deductible, then 100%	33
Outpatient hospital services	\$35 deductible, then 100%	\$100 deductible, then 100%	50

All services must be medically necessary and all charges are subject to the Plan's allowed amount for that service (page 19).

Table 6. Summary of Covered Services (continued)

	With CIC	Without CIC	See page
✓ Oxygen See page 21 for important information about Medicare contract suppliers and UniCare preferred vendors.	From preferred vendors: \$35 deductible, then 100% From non-preferred vendors: \$35 deductible, then 80%	From preferred vendors: \$100 deductible, then 100% From non-preferred vendors: \$100 deductible, then 80%	50
Personal Emergency Response Systems (PERS) <ul style="list-style-type: none"> ▪ Installation ▪ Rental fee 	\$35 deductible, then 80%, up to a limit of \$50 Up to \$40 each month	\$100 deductible, then 80%, up to a limit of \$50 Up to \$40 each month	51
Physical therapy	If Medicare pays: 100% of your Part B deductible and coinsurance If Medicare does not pay: \$35 deductible, then 80%	\$100 deductible, then 80%	51
Prescription drugs	Benefits are administered by SilverScript. See Part 2 of this handbook, or call SilverScript at 877-876-7214 (toll free) for more information.		97
Preventive care See Table 7 on page 59.	100%	100%	59
🏠 Private duty nursing <ul style="list-style-type: none"> ▪ Inpatient ▪ Outpatient 	\$35 deductible, then 100%, up to a limit of \$1,000 each calendar year. The limit includes benefits paid by Medicare. \$35 deductible, then 80%, up to a limit of \$8,000 each calendar year. The limit includes benefits paid by Medicare.	\$100 deductible, then 100%, up to a limit of \$1,000 each calendar year. The limit includes benefits paid by Medicare. \$100 deductible, then 80%, up to a limit of \$4,000 each calendar year. The limit includes benefits paid by Medicare.	52
Prosthetics / orthotics <ul style="list-style-type: none"> ▪ Breast prosthetics ▪ All other prosthetics and orthotics 	100% If Medicare pays: 100% of your Part B deductible and coinsurance If Medicare does not pay: 80%	100% If Medicare pays: 100% of your Part B deductible and coinsurance If Medicare does not pay: 80%	53

All services must be medically necessary and all charges are subject to the Plan's allowed amount for that service (page 19).

Table 6. Summary of Covered Services (continued)

	With CIC	Without CIC	See page
Radiation therapy	100%	80%	53
Speech therapy	\$35 deductible, then 100%, up to a limit of \$2,000 each calendar year	\$100 deductible, then 80%, up to a limit of \$2,000 each calendar year	54
Surgery (inpatient or outpatient)			54
▪ In Massachusetts	100% of your Part B deductible and coinsurance	100% of your Part B deductible and coinsurance	
▪ Outside Massachusetts	Medicare participating: 100% of your Part B deductible and coinsurance Medicare non-participating: 100% of your Part B deductible and coinsurance; then 80% of the difference between the Medicare payment and the covered charge	Medicare participating: 100% of your Part B deductible and coinsurance Medicare non-participating: 100% of your Part B deductible and coinsurance	
Tobacco cessation counseling	100%, up to 300 minutes each calendar year	100%, up to 300 minutes each calendar year	56
 Transplants			57
▪ At a Quality Center or Designated Hospital for transplants	\$50 quarterly copay, then 100%	\$100 quarterly copay, then 100%	
▪ At another hospital	\$50 quarterly copay, then 80%	\$100 quarterly copay, then 80%	

All services must be medically necessary and all charges are subject to the Plan's allowed amount for that service (page 19).

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	\$35 deductible, then 100%	100% of the first \$25

X 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	\$35 deductible, then 100%	\$100 deductible, then 100%

X 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 107-131) 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 107-131) 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	100%	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	\$35 deductible, then 100%	\$100 deductible, then 80%
Inpatient	Covered under the inpatient hospital benefit (page 44)	

Chiropractic care

Chiropractic care is covered, up to 20 visits each calendar 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	\$35 deductible, then 80%, up to a limit of 20 visits each calendar year	\$100 deductible, then 80%, up to a limit of 20 visits each calendar year

X 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.

Circumcision

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

	With CIC	Without CIC
Circumcision	100%	100%

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

X Restrictions:

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

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.

The Plan covers patient care items and services provided in a cancer clinical trial, as long as:

- The trial meets the definition of a “qualified clinical trial” as contained in Massachusetts General Laws Chapter 175, section 110L.
- The service or item is provided to an individual enrolled in a qualified clinical trial, and:
 - Is consistent with the standard of care for someone with the same diagnosis,
 - Is consistent with the study protocol for the clinical trial, and
 - Would be covered if you did not participate in the clinical trial

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.

X 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 paid for by the manufacturer, distributor or provider of the drug or device
 - 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

X 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 60).

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 <i>See page 21 for important information about Medicare contract suppliers and UniCare preferred vendors.</i>	<ul style="list-style-type: none"> ▪ From preferred vendors: \$35 deductible, then 100% ▪ From non-preferred vendors: \$35 deductible, then 80% 	<ul style="list-style-type: none"> ▪ From preferred vendors: \$100 deductible, then 100% ▪ From non-preferred vendors: \$100 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 97-106).

✓ **Use Medicare contract suppliers or UniCare preferred vendors** (page 21) – Medicare contract suppliers, when available, are the preferred vendors. Supplies from Medicare contract suppliers are covered at 100% of the allowed amount (after your deductible). Use a UniCare preferred vendor only if there is no Medicare contract supplier available.

 To find Medicare contract suppliers, go to medicare.gov/supplier. 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	\$35 deductible, then 100%	\$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
Office visits	\$35 deductible, then 100%	\$100 deductible, then 100%
Inpatient hospital	100%	100%
Emergency treatment	100%	100%

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
Durable medical equipment <i>See page 21 for important information about Medicare contract suppliers and UniCare preferred vendors.</i>	<ul style="list-style-type: none"> ▪ From preferred vendors: \$35 deductible, then 100% ▪ From non-preferred vendors: \$35 deductible, then 80% 	<ul style="list-style-type: none"> ▪ From preferred vendors: \$100 deductible, then 100% ▪ From non-preferred vendors: \$100 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.

X Restrictions:

- The 20% coinsurance does not count toward the CIC out-of-pocket limit.
- 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.

 **Use Medicare contract suppliers or UniCare preferred vendors** (page 21) – Medicare contract suppliers, when available, are the preferred vendors. DME and related supplies from Medicare contract suppliers are covered at 100% of the allowed amount (after your deductible). Use a UniCare preferred vendor only if there is no Medicare contract supplier available.

 To find Medicare contract suppliers, go to medicare.gov/supplier. 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	\$25 copay, then 100% (copay is waived if admitted)	\$25 copay, then 100% (copay is waived if admitted)
Laboratory testing	100%	100%
Radiology	100%	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, you may also owe 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	<ul style="list-style-type: none"> ▪ From preferred vendors: \$35 deductible, then 100% ▪ From non-preferred vendors: \$35 deductible, then 80% 	<ul style="list-style-type: none"> ▪ From preferred vendors: \$100 deductible, then 100% ▪ From non-preferred vendors: \$100 deductible, then 80%

Restrictions:

- The 20% coinsurance does not count toward the CIC out-of-pocket limit.

 **Notify UniCare** – Contact UniCare Customer Service at least one business day before services start if Medicare won't cover the full amount of the requested services.

 **Use preferred vendors** (page 21) – 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 unicarestatplan.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	\$10 copay, then 100%; covered once every 24 months	\$10 copay, then 100%; covered once every 24 months
Eye care office visits When medically necessary	\$35 deductible, then 100%	\$100 deductible, then 100%

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, neither Medicare nor the Medicare Extension plan 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	100%; limited to the initial lenses within six months after an eye injury or cataract surgery	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.

 **Important!** Medicare only pays for contact lenses or eyeglasses from a supplier enrolled in Medicare, no matter who submits the claim (you or the supplier). If you use an un-enrolled supplier, the Medicare Extension plan covers only 20% of the allowed amount. You must pay the rest of the cost yourself.

 To look for a Medicare-enrolled supplier near you, go to [medicare.gov/supplier](https://www.medicare.gov/supplier).

Family planning and hormone replacement

Office visits and procedures for the purpose of **family planning** (contraception) and services related to hormone replacement therapy for perimenopausal and postmenopausal women (women going through menopause) 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, as well as hormone replacement 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 calendar year	\$100 per family each calendar year

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

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

X Restrictions:

- Although any family member may have the fitness membership, the reimbursement is a one-time payment each calendar 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	\$35 deductible, then 100%	\$100 deductible, then 100%

X Restrictions:

- Arch supports are not covered.

Formulas (special)

Low-protein food products used for inherited diseases of amino acids and organic acids are covered.

Certain special medical formulas, which are available through your prescription drug plan, are covered in accordance with state law. The formula must be prescribed by a physician to treat one of the following conditions in your child (or your fetus, where noted):

- Phenylketonuria (child and fetus)
- Tyrosinemia
- Homocystinuria
- Maple syrup urine disease
- Propionic acidemia or methylmalonic acidemia

Other prescription and non-prescription enteral formulas are covered 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
- Inherited diseases of amino acids and organic acids

The medical plan provides coverage for inherited diseases of amino acids and organic acids. This coverage includes low-protein food products.

X Restrictions:

- Low-protein food products are covered up to \$2,500 each calendar year per member.

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	\$35 deductible, then 100%	\$100 deductible, then 100%

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	\$35 deductible, then 100% of the first \$500, then 80% of the next \$1,500, up to a limit of \$1,700 every 24 months	\$100 deductible, then 100% of the first \$500, then 80% of the next \$1,500, up to a limit of \$1,700 every 24 months

X Restrictions:

- The 20% coinsurance does not count toward the CIC out-of-pocket limit.
- 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	\$35 deductible, then 100%	\$100 deductible, then 100%
Hearing screenings for newborns	100%	100%

X 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	<ul style="list-style-type: none"> ■ From preferred vendors: \$35 deductible, then 100% ■ From non-preferred vendors: \$35 deductible, then 80% 	<ul style="list-style-type: none"> ■ From preferred vendors: \$100 deductible, then 100% ■ From non-preferred vendors: \$100 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 33)

- ❑ 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 if Medicare won't cover the full amount of the requested services.

✓ **Use preferred vendors** (page 21) – 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 unicarestateline.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	<ul style="list-style-type: none"> ■ From preferred vendors: \$35 deductible, then 100% ■ From non-preferred vendors: \$35 deductible, then 80% 	<ul style="list-style-type: none"> ■ From preferred vendors: \$100 deductible, then 100% ■ From non-preferred vendors: \$100 deductible, then 80%

✕ Restrictions:

- The 20% coinsurance does not count toward the CIC out-of-pocket limit.
- Subcutaneous and intramuscular drugs must be obtained through your prescription drug plan.

✓ **Use preferred vendors** (page 21) – 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 unicarestateline.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.

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 six months or less to live.

	With CIC	Without CIC
Hospice care	\$35 deductible, then 100%	\$100 deductible, then 100%
Bereavement counseling	\$35 deductible, then 80%, up to a limit of \$1,500 per family	\$100 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

X Restrictions:

- The 20% coinsurance for bereavement counseling does not count toward the CIC out-of-pocket limit.
- Bereavement counseling is limited to \$1,500 per family. Additional bereavement services may be available under the behavioral health benefit (see pages 107-131).
- Respite care is limited to a total of five days.
- 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)

X Restrictions:

- Experimental infertility procedures are not covered.
- 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	\$50 quarterly copay, then 100%	\$100 quarterly copay, then 100%
Private room When medically necessary	\$50 quarterly copay, then 100% of the semi-private room rate	\$100 quarterly copay, then 100% of the semi-private room rate
Diagnostic laboratory and radiology expenses	100%	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

X 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.

Medicare covers 60 days at 100% after Medicare's deductible for medically necessary hospital care that occurs within a "benefit period." Those 60 days can occur as a result of one or multiple hospitalizations.

A benefit period starts the day you are first admitted to a hospital and ends when you have been out of a hospital or skilled nursing facility for 60 straight days. The benefit period also ends if you are in a skilled nursing facility but have not gotten skilled care in that facility for 60 straight days.

After that 60-day period, the next time you are admitted to a hospital, a new benefit period starts and your Medicare benefits for hospital and skilled care are renewed. There is no limit on the number of Medicare benefit periods that you can have. If you have additional questions about your Medicare benefits, please consult the *Medicare & You* handbook or call your local Social Security office.

Depending on the benefits available to you from Medicare, a nurse reviewer will determine the need for a review of your hospitalization. The 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 within 24 hours. For an emergency admission, UniCare will contact the hospital directly. In addition, both you and your provider will be notified in writing or electronically within two business days 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 F).

Continued stay review

Notify the Plan if your stay in any hospital adds up to or is near 60 days within one benefit period. When this occurs, the nurse reviewer will review the continuing hospital stay. The nurse reviewer may call your provider while you are in the hospital to determine whether a continued hospital stay is eligible for benefits under the Plan. 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 F).

Concurrent review

A concurrent review is a review that takes place during a hospital stay, either for a continued stay (see above) or for additional services.

The Plan will make a concurrent review determination and notify your provider by telephone or fax within one business day of getting all necessary information. The notice will include the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or start of services.

If the nurse reviewer is unable to make a determination, your provider will be offered the opportunity to speak with a physician advisor before the Plan makes a final decision.

Adverse determinations

If the Plan determines that the continued stay or service is not eligible for benefits, the nurse reviewer will notify you (or your authorized representative) and your provider by telephone within 24 hours, and will provide written or electronic notification within one additional business day. You will continue to get services without any liability for services received until you, or your authorized representative, have been notified.

The written notice will tell you about your right to an internal expedited appeal, including the right to a decision before you are discharged.

The Plan's written notice will include a substantive clinical justification that is consistent with generally-accepted principles of professional medical practice. This notice will include:

- The specific information that the adverse determination was based on
- Your presenting symptoms or condition; diagnosis and treatment interventions; and the specific reasons why the medical evidence doesn't meet the generally-accepted principles of medical practice
- Any alternative treatment option offered by the Plan, and
- Applicable clinical practice guidelines and review criteria

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
For days paid by Medicare	\$35 deductible, then 100% of your Part A deductible and coinsurance for up to 100 days; then 80% for the rest of the year, up to a limit of \$10,000 each calendar year	\$100 deductible, then 100% of your Part A deductible and coinsurance for up to 100 days; then 80% for the rest of the year, up to a limit of \$7,500 each calendar year
For days <i>not</i> paid by Medicare	80%, up to a limit of \$10,000 each calendar year	80%, up to a limit of \$7,500 each calendar 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

X Restrictions:

- Whether or not Medicare pays, the coinsurance does not count toward the CIC out-of-pocket limit.
- 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 and radiology services

Laboratory and radiology services (such as X-rays) are covered when they are prescribed by a physician.

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 lab / radiology	100%	100%
Outpatient lab / radiology	100%	80%
Emergency room lab / radiology	100%	100%

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)	\$35 deductible, then 100%	\$100 deductible, 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.

X Restrictions:

- Services at hospital-owned medical clinics may be covered as emergency room care (page 35) or outpatient hospital care (page 50), 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)	\$35 deductible, then 80%	\$100 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 60).
- Children under 18 are covered as part of being treated for cleft lip or cleft palate (page 29).
- Members with diabetes are covered under the benefit for diabetes care (page 31).
- 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	<ul style="list-style-type: none"> ▪ If Medicare pays: 100% of your Part B deductible and coinsurance ▪ If Medicare does <i>not</i> pay: \$35 deductible, then 80% 	\$100 deductible, then 80%

X Restrictions:

- Group occupational therapy is not covered.

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	\$35 deductible, then 100%	\$100 deductible, then 100%

Oxygen

Oxygen and its administration are covered.

	With CIC	Without CIC
Oxygen <i>See page 21 for important information about Medicare contract suppliers and UniCare preferred vendors.</i>	<ul style="list-style-type: none"> ▪ From preferred vendors: \$35 deductible, then 100% ▪ From non-preferred vendors: \$35 deductible, then 80% 	<ul style="list-style-type: none"> ▪ From preferred vendors: \$100 deductible, then 100% ▪ From non-preferred vendors: \$100 deductible, then 80%

Restrictions:

- The 20% coinsurance does not count toward the CIC out-of-pocket limit.
 - Oxygen equipment required for use on an airplane or other means of travel is not covered.
-  **Use Medicare contract suppliers or UniCare preferred vendors** (page 21) – Medicare contract suppliers, when available, are the preferred vendors. Supplies from Medicare contract suppliers are covered at 100% of the allowed amount (after your deductible). Use a UniCare preferred vendor only if there is no Medicare contract supplier available.
-  To find Medicare contract suppliers, go to medicare.gov/supplier. To find UniCare preferred vendors, go to the *Members* page of unicarestaateplan.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	\$35 deductible, then 80%, up to a limit of \$50	\$100 deductible, then 80%, up to a limit of \$50
Rental fee	Limited to \$40 each month	Limited to \$40 each month

X Restrictions:

- The 20% coinsurance does not count toward the CIC out-of-pocket limit.
- 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	<ul style="list-style-type: none"> ■ If Medicare pays: 100% of your Part B deductible and coinsurance ■ If Medicare does <i>not</i> pay: \$35 deductible, then 80% 	\$100 deductible, then 80%

X 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.

Prescription drugs

Benefits for prescription drugs are administered by SilverScript. See Part 2 (pages 97-106) 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 59-62.

	With CIC	Without CIC
Preventive care	100%	100%

X 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 provided by a registered nurse.

	With CIC	Without CIC
Inpatient Must not duplicate services that the facility is licensed to provide	\$35 deductible, then 100%, up to a limit of \$1,000 each calendar year. The limit includes benefits paid by Medicare.	\$100 deductible, then 100%, up to a limit of \$1,000 each calendar year. The limit includes benefits paid by Medicare.
Outpatient When you are confined to your home	\$35 deductible, then 80%, up to a limit of \$8,000 each calendar year. The limit includes benefits paid by Medicare.	\$100 deductible, then 80%, up to a limit of \$4,000 each calendar year. The limit includes benefits paid by Medicare.

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.

X Restrictions:

- The 20% coinsurance does not count toward the CIC out-of-pocket limit.
- Outpatient private duty nursing is provided only at your home, when you are confined to your home.
- 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** at least one business day before services start, if Medicare won't cover the full amount of the requested services.

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	100%	100%
Orthopedic shoe with attached brace	100%	100%
All other prosthetics and orthotics	<ul style="list-style-type: none"> ▪ If Medicare pays: 100% of your Part B deductible and coinsurance ▪ If Medicare does <i>not</i> pay: 80% 	<ul style="list-style-type: none"> ▪ If Medicare pays: 100% of your Part B deductible and coinsurance ▪ If Medicare does <i>not</i> pay: 80%

Orthotics must be:

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

X 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	100%	80%

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	100%	80%

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	\$35 deductible, then 100%, up to a limit of \$2,000 each calendar year	\$100 deductible, then 80%, up to a limit of \$2,000 each calendar year

Covered speech therapy services include:

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

X 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
In Massachusetts	100% of your Part B deductible and coinsurance	100% of your Part B deductible and coinsurance
Outside Massachusetts	<ul style="list-style-type: none"> ▪ Medicare participating: 100% of your Part B deductible and coinsurance ▪ Medicare non-participating: 100% of your Part B deductible and coinsurance, then 80% of the difference between the Medicare payment and the covered charge 	<ul style="list-style-type: none"> ▪ Medicare participating: 100% of your Part B deductible and coinsurance ▪ Medicare non-participating: 100% of your Part B deductible and coinsurance

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 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.

X 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.

Tobacco cessation counseling

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

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

X Restrictions:

- Tobacco cessation counseling is limited to 300 minutes each calendar 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	\$50 quarterly copay, then 100%	\$100 quarterly copay, then 100%
At another hospital	\$50 quarterly copay, then 80%	\$100 quarterly copay, 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

X Restrictions:

- The 20% coinsurance does not count toward the CIC out-of-pocket limit.

📞 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 75 for more information about case management.)
- You do not need to notify UniCare for cornea transplants.

Bone marrow transplant for members diagnosed with breast cancer

The Plan provides coverage for a bone marrow transplant or transplants if you have been diagnosed with metastatic breast cancer, provided you meet the criteria established by the Massachusetts Department of Public Health.

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. Transplants at other hospitals are covered at 80% after the copay. 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%

X 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 66.

Wigs

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

	With CIC	Without CIC
Wigs	80%, up to a limit of \$350 each calendar year	80%, up to a limit of \$350 each calendar year

X Restrictions:

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

Schedule of preventive care services

Table 7 shows the preventive services covered under the Plan. Benefits for the services listed here are covered at 100% subject to the gender, age and frequency guidelines indicated. Preventive exams are covered according to the schedule issued by Massachusetts Health Quality Partners.

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 7. 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	■	■	■	■		
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
Chlamydia screening		■	■	■		
Cholesterol abnormalities screening	■	■	■			Every 12 months

Table 7. Preventive Care Schedule (continued)

Preventive Service	Men	Women	Pregnant Women	Children	Age	Frequency
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 64)	■	■			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 67)	■	■	■			Covered as a component of your preventive exam
Fluoride varnish for children, starting at the age of primary tooth eruption				■	Up to age 5	
Gonorrhea screening		■	■			Every 12 months
Gonorrhea, prophylactic medication (newborns)				■		
Gynecological examination		■				Every 12 months
Hearing loss screening (newborns)				■		
Hepatitis B screening	■	■	■	■		
Hepatitis C screening	■	■	■	■		
HIV screening	■	■	■	■		
Human papillomavirus (HPV) DNA test		■	■		30 and older	Every 3 years for women with normal cytology results
Hypothyroidism screening (newborns)				■		
Immunizations	■	■	■	■		

Table 7. Preventive Care Schedule (continued)

Preventive Service	Men	Women	Pregnant Women	Children	Age	Frequency
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)				■		
Preventive exams for children up to age 19				■		<ul style="list-style-type: none"> ▪ 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
Prostate cancer screening (digital rectal exam and PSA test)	■				50 and older	<ul style="list-style-type: none"> ▪ Digital exam – Covered as a component of your preventive exam ▪ PSA test – Every 12 months

Table 7. Preventive Care Schedule (continued)

Preventive Service	Men	Women	Pregnant Women	Children	Age	Frequency
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	■	■	■	■		
Visual impairment screening	■	■	■	■		Covered as a component of your preventive exam
Additional covered preventive screening laboratory tests for adults: <ul style="list-style-type: none"> ▪ Hemoglobin ▪ Urinalysis ▪ Chemistry profile, including: <ul style="list-style-type: none"> ▪ 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 CIC out-of-pocket limit.

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 107-131).
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 107-131) 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 29) 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 30 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.
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 #70).
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 calendar 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) **Reversal of voluntary sterilization** is not covered.
 - c) **Sperm, egg and/or inseminated egg procurement** and processing, and banking of sperm or inseminated eggs, are covered only for the treatment of infertility.
 - d) **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 52)
 - A service or supply that qualifies as a covered hospice care service (page 42)

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 one visit every 12 months)
 - Children under 18 with cleft lip / palate (page 29)
 - Members with certain eating disorders (see Part 3 of this handbook)
 - Members with diabetes (page 31)
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. **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.
61. **Religious facilities** – Services received at non-medical religious facilities are not covered.

62. **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.
63. **Routine screenings** are not covered except according to the preventive care schedule (pages 59-62).
64. **Schools** – There is no coverage for any services or treatments required under law to be provided by the school system for a child.
65. **Sensory integration therapy** is not covered.
66. **Shipping costs**, such as the cost of shipping eggs or sperm between fertility clinics, are not covered.
67. **Stairway lifts** and **stair ramps** are not covered.
68. **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.
69. **Surface electromyography (SEMG)** is not covered.
70. **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.
71. **Telephone consultations** are not covered (also see restriction #70).
72. **Thermal therapy** – Any type of hot or cold thermal therapy device is not covered.
73. **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.
74. **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.
75. **Tobacco cessation counseling** is limited to 300 minutes each calendar year.
76. **Transportation** to medical appointments, including to dialysis treatment, is not covered.
77. **Travel time** – There is no coverage for travel time to or from appointments for medical care.
78. **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
79. **Vision therapy** is not covered.

80. **Voice therapy** is not covered.
81. **Web and Internet-based services** – There is no coverage for services obtained from websites or from providers over the Internet (also see restriction #70).
82. **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.
83. **Wigs** are covered only for the replacement of hair loss resulting from treatment of any form of cancer or leukemia.
84. **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.
85. **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.

Tell UniCare about certain medical care

- ❑ Be sure to notify UniCare if you will be having any of the services or procedures listed on page 15. Your benefit may be reduced by up to \$500 if you don't let UniCare know when you're getting one of these services. 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. See page 15 for a list of the services that require notice. See “How medical services get reviewed” on page 74 for information about the review process.

Use Medicare participating providers

- ❑ Your benefits are highest when you use Medicare participating providers – providers who have agreed to accept Medicare's payment as payment in full for covered services. If you get care outside of Massachusetts, participating providers will not balance bill you for charges over the allowed amount, but other providers are free to do so. You should always check to make sure that any new providers are Medicare participating providers.

See “How the providers you use can affect your costs” on page 20 to find out more about the different types of Medicare providers.

Use Medicare contract suppliers or UniCare preferred vendors

- ❑ For some services and supplies, you'll have the best coverage when you use a preferred vendor. For services and supplies that are in Medicare's competitive bidding program, the preferred vendors are Medicare contract suppliers. Your costs are covered at 100% of the allowed amount when you get covered items from a Medicare contract supplier. If a Medicare contract supplier is available, costs from non-contract suppliers are not covered by either Medicare or UniCare.

If there is no Medicare contract supplier that you can use, you'll be covered at 100% of the allowed amount when you use a UniCare preferred vendor. If you use a non-preferred vendor, the coverage is 80% and you'll owe 20% coinsurance. (Note that your deductible may also apply, no matter which type of vendor you use.)

In this handbook, the **checkmark** ✓ identifies services that have contract suppliers and/or preferred vendors. For more information, see “About preferred vendors” on page 21.

Keep your UniCare card on hand

- ❑ Keep both your UniCare ID card and your Medicare card with you at all times, and always show them when you get medical care. That way, the provider can confirm your eligibility for benefits.

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.

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.

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.

Hospitals

As a UniCare member, you can use any hospital at the same level of coverage. If you get care outside of Massachusetts, be sure to use hospitals that accept Medicare payment so you don't get balance billed for any charges above the Plan's allowed amount.

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.

Medicare participating providers

Participating providers are health care providers who have signed an agreement with Medicare to accept Medicare assignment; that is, they agree to accept Medicare's payment as payment in full for covered services. No matter where you live, participating providers will not balance bill you for charges over the allowed amount. See "How the providers you use can affect your costs" on page 20 to find out more.

Preferred vendors

Preferred vendors (page 21) are providers who have contracted with Medicare or UniCare for certain services. When you get these services from a Medicare contract supplier (when available) or a UniCare preferred vendor, they are covered at 100% (after your deductible, if it applies).

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

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

How to find providers

 To find health care providers, including providers in Massachusetts and preferred vendors, go to the *Members* page at unicarestatement.com and choose *Find a doctor*. To find a Medicare contract supplier, go to medicare.gov/supplier.

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

How UniCare reimburses providers

UniCare reimburses providers on a fee-for-service basis. UniCare does not withhold portions of benefit payments from providers or offer providers incentive payments to control the use of services. Explanations of provider payments are detailed in your *Explanations of Benefits* (EOB). In this Plan, providers may discuss the nature of the way they are compensated with you.

How claims are processed

Before UniCare can process your claims, your claims must first be submitted to Medicare for consideration. Most hospitals, physicians or other health care providers will submit claims to Medicare for you. Medicare will send you an *Explanation of Medicare Benefits* (EOMB) that explains what Medicare paid and if any balance remains.

Once Medicare processes your claims, any remaining balance is automatically sent to the UniCare Customer Service Center, where benefits under the Medicare Extension plan are determined. This process is called **Medicare crossover**. You are not responsible for paying any balances until the Medicare crossover process is completed. At that time, you will receive an *Explanation of Benefits* (EOB) from UniCare.

How to submit a claim

If you need to submit your own claim, you must first submit your claim to Medicare. You must then submit written proof of the claim, including the following information, to UniCare Customer Service:

- Medicare EOMB
- 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 unicarestatement.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 97-106). For mental health, substance use disorder and EAP claims, see Part 3 (pages 107-131).

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.

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.

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

UniCare's *Notice of Privacy Practices* appears in Appendix B. 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 UniCare's legal duties and privacy practices.

About your appeal rights

You have the right to respond to an adverse determination made by the Plan. For instructions on how to file an inquiry, complaint or grievance/appeal, see Appendix F.

Appeals for behavioral health services – These appeals must be filed with the administrator of those services. See Part 3 (pages 107-131).

Involuntary disenrollment rate

In accordance with Massachusetts Division of Insurance Regulations, UniCare reports an involuntary disenrollment rate of 0 percent for members in its Massachusetts book of business in 2015.

Reporting requirements

The Plan provides the following information to the Office of Patient Protection no later than May 15 of each year:

1. A list of sources of independently published information assessing member satisfaction and evaluating the quality of health care services offered by the Plan
2. The percentage of physicians who voluntarily and involuntarily terminated participation contracts with the Plan during the previous calendar year for which such data has been compiled, and the three most common reasons for voluntary and involuntary physician disenrollment
3. The percentage of premium revenue expended by the Plan for health care services provided to members for the most recent year for which information is available, and
4. A report detailing, for the previous calendar year, the total number of:
 - Filed grievances/appeals, grievances/appeals that were approved internally, grievances/appeals that were denied internally, and grievances/appeals that were withdrawn before resolution
 - External appeals pursued after exhausting the internal grievance/appeal process and the resolution of all such external grievances/appeals

How medical services get reviewed

As explained in “When you must provide notice about your care” on page 14, UniCare must be notified if you are scheduled to have any of the services listed in Table 1 (page 15). 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 one business day after all necessary supporting documents have been received. The decision is then communicated in writing to you and to your doctor.

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 E, “Federal and State Mandates.”

Eligibility for benefits

You are eligible to enroll in the Plan if you are (1) An Elderly Governmental Retiree or a Retired Municipal Teacher, as defined by Massachusetts General Laws, Chapter 32A, or a surviving spouse of either; and (2) Enrolled in Medicare Parts A and B .

Coverage may be denied if you do not meet the above criteria. Coverage may also be denied if you do not meet the GIC’s eligibility rules and regulations (below).

If you have a dependent who is not covered by Medicare, he or she may enroll in one of UniCare’s non-Medicare plans.

Application for coverage

You must apply to the GIC for enrollment in the Plan. To obtain the appropriate forms, contact the GIC.

You must enroll dependents when they become eligible, generally within 60 days of the qualifying event (e.g., marriage, birth, adoption). You must complete an enrollment form to enroll or add dependents and supply any required documentation required by the GIC.

When coverage begins

Coverage under the Plan starts as follows:

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 new retirees/Medicare enrollees and 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 terminates¹

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 terminates¹

Disenrollment

Voluntary termination

You may terminate your coverage during the GIC's annual enrollment or within 60 days of a qualifying event by notifying the GIC in writing. The GIC will determine the date that your coverage will end.

Disenrollment due to loss of eligibility

Coverage under the Plan may terminate or not renew if you fail to meet any of the specified eligibility requirements. You will be notified in writing if your coverage ends due to loss of eligibility.

You may be eligible for continued enrollment under federal or state law if your membership is terminated (see "Continuing coverage" on page 78).

Termination for cause

The GIC may end a member's coverage for cause. Termination of membership for cause can occur for several reasons, including:

- Providing false or misleading information on your application for membership
- Engaging in misrepresentation or fraud
- Committing acts of physical or verbal abuse (unrelated to your physical or mental condition) that threaten providers, staff at providers' offices, or other members
- Non-renewal or cancellation of the GIC contract that you receive coverage through

¹ This includes termination due to the Commonwealth's nonpayment of required premium. In this situation, your coverage under the Plan will terminate three (3) days after a notice has been mailed, first class, to your last known address (provided by the GIC). The notice will state that the Plan is terminated because the Commonwealth failed to pay the required premiums and that the Plan will honor claims for covered services you received before the termination date.

Continuation of coverage for Massachusetts residents

The information above explains why and when your insurance will normally cease. If your medical insurance ends for any reason other than the Plan's discontinuance, it will be continued beyond the date it would normally end. This occurs on the earlier of: (a) 31 days after your continued insurance began, or (b) the date you can obtain similar insurance through another plan.

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

Coverage may be continued or converted if eligibility status changes for the following reasons:

Continuing health coverage for survivors

Surviving spouses of covered 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 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.

Continued insurance of divorced spouses

You may continue to insure your former spouse under the Plan **as if the court's judgment had not been entered**, provided that:

1. The insurance is limited to the part of the Plan that covers medical or dental care or treatment, and
2. The insurance will not continue if you or your former spouse remarries (or at any other time stated in the judgment).

If required by the court's judgment, your former spouse's coverage may continue even if you remarry. In this case, he or she may either:

1. Remain insured under the Plan, and, if required by the judgment, be required to pay all or part of the cost of the insurance, or
2. Have a converted policy issued.

Provision for court support orders

If a court orders the GIC to provide medical insurance for a qualified retiree's dependent child or spouse, the GIC must notify the retiree and determine if the child or spouse is eligible for insurance under this Plan. Eligibility determinations will be made in accordance with federal and/or state laws and regulations concerning support orders. The retiree will be responsible for any required contributions under the Plan. This insurance will be effective as of the date of the support order and subject to all Plan provisions, except:

1. A qualified dependent may not be covered if the retiree is not enrolled in the Plan.
2. In addition to the regular reasons for termination of insurance (see "When coverage ends for enrollees," above), insurance required by a support order will cease on the earlier of:
 - a) The date the support order expires, or
 - b) The date the dependent child or spouse obtains similar insurance through another plan.

The Plan will honor all applicable state Medicaid laws and rules, and will not deny insurance or benefits because a person is eligible for Medicaid.

If a spouse, custodial parent, or legal guardian who is not a Plan member pays the covered expenses of a dependent child or spouse, the Plan will directly reimburse that person and not the Plan member or eligible retiree. A custodial parent or legal guardian may also sign claim forms and assign Plan benefits for a dependent child.

A child or spouse will not be considered a late applicant if a court orders that coverage be provided for that person under your plan, and the request for enrollment is made no later than 31 days after the court order is issued.

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.

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 trustee 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: Medicare and Medicare Extension

The benefits for an enrollee and his or her dependents simultaneously covered by the UniCare State Indemnity Plan/Medicare Extension 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.

Note that some providers choose not to participate in the Medicare program. If members use these providers for services that Medicare normally covers, the UniCare State Indemnity Plan will only consider for payment the amount that would have been allowed if Medicare had processed the claim as the primary carrier.

Example – Some providers choose not to participate in the Medicare program (that is, they are unenrolled providers). If you use an unenrolled provider for services that Medicare normally covers, and the charge is \$100, the UniCare State Indemnity Plan subtracts the primary plan's benefit before it pays its portion of the bill. In this case, the Plan assumes that Medicare would have paid \$80, leaving \$20 in coinsurance. The Plan will apply its benefit to the \$20, and you may be responsible you for the remainder.

Determining the order of coverage: non-Medicare plans

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

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
unicarestatement.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

SilverScript

877-876-7214 (toll free)
TDD: 800-238-0756
gic.silverscript.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 89 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 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 SilverScript (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 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 89).

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
- UniCare preferred vendors and Medicare contract suppliers
- 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 UniCare preferred vendors
- 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 preferred vendors

To find UniCare preferred vendors, choose *Find a doctor* from the unicarestateplan.com *Members* page, then select *Preferred Vendors*.

To find Medicare contract suppliers, go to medicare.gov/supplier.

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 89).

How to ask to have medical information released

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

The Patients' Bill of Rights and Office of Patient Protection

The Massachusetts Patients' Bill of Rights (as established by Chapter 141 of the Acts of 2000) lists a number of patients' rights related to access to care, coverage for emergency care, grievance processes and external reviews. Many of these rights have always been available to you under the UniCare State Indemnity Plan.

The Office of Patient Protection (OPP), also established by Chapter 141, enforces health insurance consumer protection regulations. The OPP is responsible for:

1. Developing regulations and implementing new statutory provisions governing internal grievance procedures for managed care carriers, as well as medical necessity guidelines, continuity of care and independent external reviews
2. Helping consumers with questions and concerns relating to managed care
3. Providing information about health insurance appeal rights, waivers, and other issues related to health insurance and health care
4. Developing regulations and implementing new statutory provisions governing internal grievance procedures for managed care carriers, as well as medical necessity guidelines, continuity of care and independent external reviews

You can reach the Office of Patient Protection at 800-436-7757 or mass.gov/hpc/opp.

8: Definitions

Adverse determination (page 46) – A determination by the Plan, based upon a review of information, to deny, reduce, modify or terminate a hospital admission, continued inpatient stay, or the availability of any other health care services. This determination is made for failure to meet the requirements for coverage based on medical necessity, appropriateness of the health care setting and level of care, or effectiveness.

Allowed amount (page 19) – Either the amount Medicare allows for covered services or the amount UniCare determines to be within the range of payments most often made to similar providers for the same service or supply – whichever is lower. This allowed amount may not be the same as the provider's actual charge. Allowed amounts are expressed as maximum fees in fee schedules, maximum daily rates, flat amounts or discounts from charges.

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.

Balance billing (page 19) – 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 107-131) – 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 a higher deductible and receive only 80% coverage for some services.

Coinsurance (page 17) – 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.

Complaint – Any inquiry made by you or your authorized representative to the Plan that is either not explained or resolved to your satisfaction within three business days of the inquiry, or that is a matter involving an adverse determination.

Copay / copayment (page 17) – A fixed amount (for example, \$10) 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. Under Medicare Extension, you have copays for eye exams, inpatient hospital services and emergency room visits.

Cosmetic services (page 64) – 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 64) – 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 16) – A set amount you must pay toward covered health care services before the Plan starts to pay. For example, if your deductible is \$35, 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/appeal (Appendix F) – Any verbal or written complaint submitted to the Plan that has been initiated by you or your authorized representative regarding any aspect or action of the Plan relative to you, including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services, quality of care and administrative operations.

Health insurance – A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

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).

Inquiry – Any question or concern communicated by you or your authorized representative to the Plan that is not related to an adverse determination. The Plan maintains records of each member inquiry, and the Plan’s response to the inquiry, for a period of two years. These records are subject to inspection by the Commissioner of Insurance and the Department of Public Health.

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.

Non-preferred vendor (page 21) – A vendor who does not have a contract with either UniCare or Medicare to provide certain services or equipment including, but not limited to, durable medical equipment and medical supplies. In some cases, you will have no coverage when you use a non-preferred vendor.

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 47) – 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 – CIC only (page 18) – The most you could pay during a calendar year for coinsurance. After you reach this limit, the Plan starts to pay 100% of the allowed amount. This limit doesn't include your premiums, balance-billed charges, copays, deductibles, or health care that the Plan doesn't cover. Not all coinsurance is included in the out-of-pocket limit. See Chapter 3, "Find out what's covered," to find out if there is coinsurance for a particular service.

 There is no out-of-pocket limit for non-CIC plans.

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 21) – Providers who have contracted with either Medicare or UniCare, and whose services are covered at a higher benefit level. Preferred vendors are available for:

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

 For certain durable medical equipment, prosthetics, orthotics, and other supplies, the preferred vendors are Medicare contract suppliers. For services that aren't available from Medicare contract suppliers – including services that Medicare doesn't cover but are covered by the Plan – the preferred vendors are providers that have a contract with UniCare.

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.

Visiting nurse association – An agency certified by Medicare that provides part-time, intermittent skilled care and other home care services in a person's place of residence and is licensed in any jurisdiction requiring such licensing.

8: Definitions

PART 2: PRESCRIPTION DRUG PLAN

Description of Benefits

SilverScript Employer PDP sponsored by the Group Insurance Commission

A Medicare Prescription Drug Plan (PDP) offered by SilverScript®
Insurance Company with a Medicare contract

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

Administered by
SilverScript®

Part 2: Prescription Drug Plan

Section I – Introduction

SilverScript Employer PDP sponsored by the Group Insurance Commission (SilverScript) is a Medicare-approved Part D prescription drug plan with additional coverage provided by the GIC to expand the Part D benefits. “Employer PDP” means that the plan is an employer-provided Prescription Drug Plan. The Plan is offered by SilverScript[®] Insurance Company which is affiliated with CVS Caremark[®], the GIC’s pharmacy benefit manager for UniCare State Indemnity Plan members.

This handbook gives you a summary of what SilverScript covers and what you pay. It does not list every service that SilverScript covers or list every limitation or exclusion. To get a complete list of services, call SilverScript and ask for the *Evidence of Coverage*.

You have choices about how to get your Medicare prescription drug benefits

As a Medicare beneficiary, you can choose from different Medicare prescription drug coverage options:

- SilverScript Employer PDP sponsored by the Group Insurance Commission** as the prescription drug coverage for members of UniCare State Indemnity Plan/Medicare Extension
- One of the GIC’s other Medicare plans

You make the choice. However, **if you decide to enroll in Medicare Extension but choose not to be enrolled in or are disenrolled from SilverScript Employer PDP sponsored by the GIC, you will lose your GIC medical, prescription drug and behavioral health coverage.**

Information in this handbook

- Things to Know About SilverScript
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print. This document may be available in languages other than English. For additional information, call SilverScript at 877-876-7214, available 24 hours a day, 7 days a week. TTY users should call 711.

Este documento está disponible en otros formatos tales como Braille y en letras grandes. Este documento podría estar disponible en un idioma distinto al inglés. Para obtener información adicional, llámenos al 877-876-7214, las 24 horas del día, los 7 días de la semana. Los usuarios de teléfono de texto (TTY) deben llamar al 711.

Things to Know About SilverScript

SilverScript Phone Numbers and Website

- ❑ Call toll free 877-876-7214. TTY users should call 711.
- ❑ Website: gic.silverscript.com.

Hours of Operation

You can call us 24 hours a day, 7 days a week.

Who can join?

To join SilverScript, you must

- ❑ Be eligible for Medicare Part A for free, and enrolled in Medicare Part B, and
- ❑ Live in our service area which is the United States and its territories, and
- ❑ Meet any additional requirements established by the GIC.

Which drugs are covered?

The plan will send you a list of commonly used prescription drugs selected by SilverScript and **covered under the Medicare Part D portion of the plan**. This list of drugs is called a *Formulary*.

You may review the complete plan formulary and any restrictions on the website at gic.silverscript.com. Or call SilverScript and you will be sent a copy of the formulary. This formulary does not include drugs covered through the additional coverage provided by the GIC.

The formulary may change throughout the year. Drugs may be added, removed or restrictions may be added or changed. These restrictions include:

- ❑ **Quantity Limits (QL)** – For certain drugs, SilverScript limits the amount of the drug that it will cover.
- ❑ **Prior Authorization (PA)** – SilverScript requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from us before we fill your prescription. If you don't get approval, SilverScript will not cover the drug.
- ❑ **Step Therapy (ST)** – In some cases, SilverScript requires you to first try a certain drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, SilverScript will not cover Drug B unless you try Drug A first. If Drug A does not work for you, SilverScript will then cover Drug B.

How will I determine my drug costs?

SilverScript groups each medication into one of three tiers:

- ❑ **Generic drugs (Tier 1)** – most cost effective drugs to buy. The active ingredients in generic drugs are exactly the same as the active ingredients in brand drugs whose patents have expired. They are required by the Food and Drug Administration (FDA) to be as safe and effective as the brand drug.
- ❑ **Preferred Brand drugs (Tier 2)** – brand drugs that do not have a generic equivalent and are included on a preferred drug list. They are usually available at a lower cost than Non-Preferred Brand drugs.
- ❑ **Non-Preferred Brand drugs (Tier 3)** – brand drugs that are not on a preferred drug list and usually are a high cost.

You will need to use your formulary to find out the tier for your drug or if there are any restrictions on your drug, as well as to determine your cost. The amount you pay depends on the drug's tier and whether you are in the Initial Coverage, Coverage Gap or Catastrophic Coverage stage. If the actual cost of a drug is less than your normal copay for that drug, you will pay the actual cost, not the higher copay amount.

Additional drugs covered by the GIC

The GIC provides additional coverage to cover drugs that are not included on the SilverScript formulary, as well as certain drugs not covered under Medicare Part D, such as:

- Prescription drugs when used for anorexia, weight loss or weight gain
- Prescription drugs when used for the symptomatic relief of cough or cold
- Prescription vitamins and mineral products not covered by Part D
- Prescription drugs when used for treatment of sexual or erectile dysfunction
- Certain diabetic drugs and supplies not covered by Part D
- Prescription drugs for tobacco cessation
- Part B products, such as oral chemotherapy agents

These drugs are not subject to SilverScript appeals and exceptions process and the cost of these drugs will not count towards your Medicare out-of-pocket costs or Medicare total drug costs. There may be other drugs covered by the additional coverage from the GIC. Contact SilverScript for details.

Which pharmacies can I use?

The plan has a network of pharmacies, including retail, mail-order, long-term care and home infusion pharmacies. You must use a SilverScript network pharmacy, unless it is an emergency or non-routine circumstance.

SilverScript has **preferred** network retail pharmacies where you can get up to a 90-day supply of your maintenance medications for the same copay as mail order. You will also be able to get up to a 90-day supply of your maintenance medication at **non-preferred** network retail pharmacies, but the copay will be three times the retail 30-day supply copay.

The pharmacies in SilverScript's network can change at any time. To find a preferred or non-preferred network pharmacy near your home or where you are traveling in the United States or its territories, use the pharmacy locator tool on the website at gic.silverscript.com or call SilverScript at 877-876-7214, 24 hours a day, 7 days a week. TTY users should call 711.

You may use an out-of-network pharmacy only in an emergency or non-routine circumstance. If you use an out-of-network pharmacy, you may be required to pay the full cost of the drug at the pharmacy. In this case, you must complete a paper claim and send it to SilverScript to request reimbursement. You are responsible for your copay and will be reimbursed the plan's share of the cost.

If you may need to get your prescription filled while you are traveling outside the country, contact SilverScript Customer Care **before** you leave the U.S. You can request a vacation override for up to a 90-day supply of your medication. If you are traveling outside of the country and have an emergency drug expense, submit your itemized receipt with the completed SilverScript claim form to the GIC at P.O. Box 8747, Boston, MA 02114.

Claim forms are available at gic.silverscript.com or by calling 877-876-7214.

Please note: Veterans Affairs (VA) pharmacies are not permitted to be included in Medicare Part D pharmacy networks. The federal government does not allow you to receive benefits from more than one government program at the same time.

If you are eligible for VA benefits, you may still use VA pharmacies under your VA benefits. However, the cost of those medications and what you pay out-of-pocket will not count toward your Medicare out-of-pocket costs or Medicare total drug costs. Each time you get a prescription filled, you can compare your GIC benefit through SilverScript to your VA benefit to determine the best option for you.

Section II – Summary of Benefits

How Medicare Part D Stages Work

The **standard Medicare Part D plan** has four stages or benefit levels. This is how these stages work in 2016:

Table 8. How Medicare Part D Stages Work

Stage	Standard Medicare Part D Plan <u>without</u> your additional coverage provided by the GIC	SilverScript <u>with</u> your additional coverage provided by the GIC <u>This is what you pay</u>
Deductible	\$ 360	\$ 0
Initial Coverage	After meeting the deductible, a person pays 25% of the drug cost until he reaches \$3,310 in total drug costs	Since you have no deductible, you start in this stage and pay your GIC copay.
Coverage Gap	Also called the “donut hole,” this is when a person pays a large portion of the cost, either <ul style="list-style-type: none"> ▪ 45% brand-name drug cost ▪ 58% generic drug cost 	You continue to pay only your GIC copay.
Catastrophic Coverage	After you reach \$4,850 in Medicare Part D out-of-pocket costs, a person pays the greater of : <ul style="list-style-type: none"> ▪ 5% of the drug cost, or ▪ \$2.95 for generic drugs ▪ \$7.40 for brand-name drugs 	After you reach \$4,850 in Medicare Part D out-of-pocket costs, you pay the lower of : <ul style="list-style-type: none"> ▪ Your GIC copay, <i>or</i> ▪ The Medicare Catastrophic Coverage cost-share, the greater of <ul style="list-style-type: none"> ▪ 5% of the drug cost, or ▪ \$2.95 for generic drugs ▪ \$7.40 for brand-name drugs

In 2016, the standard Medicare Part D plan maximum out-of-pocket expense of \$4,850 includes the deductible, any amount you have paid for your copay, any amount you have paid during the coverage gap, any manufacturer discounts on your brand-name drugs in the coverage gap, and any amount paid by Extra Help or other governmental or assistance organizations on your behalf.

Medicare’s maximum out-of-pocket cost does not include the monthly premium, if any, the cost of any prescription drugs not covered by Medicare, any amount paid by SilverScript, or any amount paid through the additional coverage provided by the GIC.

Your Prescription Drug Benefits – Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

PART 2:
Prescription Drug Plan

SilverScript	
How much is the monthly premium?	<p>There is no separate prescription drug premium. This benefit is provided as part of your medical coverage.</p> <p>If you have any questions about your premium, contact the GIC’s Public Information Unit at 617-727-2310, ext. 1 (TTY users: 617-227-8583); available 8:45 a.m. to 5:00 p.m., Monday through Friday.</p>

If your individual income is over \$85,000, or if your income is over \$170,000 and you are married filing your taxes jointly, you will be required to pay an income-related additional monthly premium to the federal government in order to maintain your Medicare prescription drug coverage. This premium is adjusted based on your income.

You will receive a letter from Social Security letting you know if you have to pay this extra amount. This letter will explain how they determined the amount you must pay and the actual Income Related Monthly Adjustment Amount (IRMAA).

If you are responsible for an additional premium the extra amount will be deducted automatically from your Social Security check. If your Social Security check is not enough to cover the additional premium, Medicare will send you a bill. You do not pay this amount to the GIC or SilverScript. You send your payment to Medicare.

For more information about the withholdings from your check, visit socialsecurity.gov/mediinfo.htm, call 800-772-1213, 7 a.m. to 7 p.m., Monday through Friday, or visit your local Social Security office. TTY users should call 800-325-0778.

For more information about Part D premiums based on income, call Medicare at 800-MEDICARE (800-633-4227).

SilverScript	
How much is the deductible?	This plan does not have a deductible.

SilverScript	
Initial Coverage	<p>You pay the amounts below until your total yearly drug costs reach \$3,310. Total yearly drug costs are the total drug costs for Part D drugs paid by both you and the plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies. Some of our network pharmacies are preferred network retail pharmacies. You pay the same as mail order for a 90-day supply of a maintenance medication at preferred network retail pharmacies.</p>

		SilverScript		
		Up to a 30-day supply at a retail network pharmacy	Up to a 90-day supply at a <u>preferred</u> retail network pharmacy	Up to a 90-day supply at a <u>non-preferred</u> retail network pharmacy
Tier 1	Generic	\$10	\$25	\$30
Tier 2	Preferred Brand	\$30	\$75	\$90
Tier 3	Non-Preferred Brand	\$65	\$165	\$195

		SilverScript
		Up to a 90-day supply through the mail order pharmacy
Tier 1	Generic	\$25
Tier 2	Preferred Brand	\$75
Tier 3	Non-Preferred Brand	\$165

		SilverScript
		Up to a 34-day supply at a long-term care (LTC) facility
Tier 1	Generic	\$10
Tier 2	Preferred Brand	\$30
Tier 3	Non-Preferred Brand	\$65

		SilverScript
Coverage Gap	Due to the additional coverage provided by the GIC, you pay the same copay that you paid during the Initial Coverage stage. You will see no change in your copay until you qualify for Catastrophic Coverage.	

SilverScript

- Catastrophic Coverage** After you reach \$4,850 in Medicare out-of-pocket drug costs for the year, you pay the **lower** of:
- Your GIC copay, or
 - Medicare’s Catastrophic Coverage, which is the **greater** of
 - 5% of the cost, or
 - \$2.95 copay for generic, including brand drugs treated as generic, or
 - \$7.40 copay for all other drugs

SilverScript Employer PDP is a Prescription Drug Plan. This plan is offered by SilverScript Insurance Company, which has a Medicare contract. Enrollment depends on contract renewal.

Multi-Language Insert

Multi-Language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 877-876-7214. Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 877-876-7214. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电877-876-7214。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 877-876-7214。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 877-876-7214. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 877-876-7214. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 877-876-7214 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 877-876-7214. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 877-876-7214 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 877-876-7214. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول بمساعدتك. على مترجم فوري، ليس عليك سوى الاتصال بنا على 7214-876-877 سيقوم شخص ما يتحدث العربية هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 877-876-7214 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 877-876-7214. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 877-876-7214. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 877-876-7214. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 877-876-7214. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがあります。通訳をご用命になるには、 877-876-7214 にお電話ください。日本語を話す人 者が支援いたします。これは無料の サービスです。

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.**



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 network and is a Medicare participating provider.

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 not covered by Medicare. 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:

- If you receive services from a non-Medicare participating provider or;
- If you receive treatment that is not covered by Medicare.

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.

¹ Supervisors monitor random calls to Beacon Health Options' customer services department as part of Beacon's quality control program.

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.

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 \$100 per person for out-of-network behavioral health treatment, which applies only to covered 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.)

Coinsurance – The amount you pay for certain services under Beacon. The amount of coinsurance is a percentage of the total amount for the service; the remaining percentage is paid by Beacon. The provider is responsible for billing the member for the remaining percentage.

Out-of-Pocket Limit – The out-of-pocket limit is the maximum amount you will pay in deductibles, copays and coinsurance for your 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 9, 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 \$1,000 per person and is separate from your in-network medical expenses. This limit applies only to your copays for in-network behavioral health services. Once you reach your in-network out-of-pocket limit in a plan year, all 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, copays and coinsurance. 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, and Medicare participating providers are not permitted to charge more than the Medicare-approved amount. **You won’t be balance billed as long as you use in-network providers that participate in Medicare.** Call Beacon at 855-750-8980 (TDD: 866-727-9441) for help finding an in-network, Medicare participating provider.

You have a **deductible** of \$100 per person for out-of-network mental health and substance use disorder treatment.

The **out-of-pocket limit for out-of-network services** is \$1,000 per person and is separate from your out-of-network medical expenses. This limit applies only to your deductible and copays for out-of-network behavioral health services. Once you reach your out-of-network out-of-pocket limit in a plan year, all out-of-network behavioral health services you receive 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 9 outlines your costs for mental health, substance use disorder and EAP services.

Table 9. Mental Health, Substance Use Disorder, and EAP Benefits for Medicare Members

Covered Services	In-Network Benefits	Out-of-Network Benefits
Deductible <i>Applies only to behavioral health services</i>	None	\$100 per person
Out-of-Pocket Limit <i>Applies only to behavioral health services</i>	\$1,000 per person	\$3,000 per person
Inpatient Care¹		
Mental Health General hospital or psychiatric hospital	\$50 inpatient care copay per quarter ²	\$150 inpatient care copay per quarter, ² then 80% coverage of the allowed amount. Subject to deductible.
Substance Use Disorder General hospital or substance use disorder facility	\$50 inpatient care copay per quarter ²	\$150 inpatient care copay per quarter, ² then 80% 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	\$50 inpatient care copay per quarter ²	\$150 inpatient care copay per quarter, ² then 80% coverage of the allowed amount. Subject to deductible.
Outpatient Care – Mental Health, Substance Use Disorder and Enrollee Assistance Program		
Individual and Family Therapy³	First 4 visits: no copay Visits 5 and over: \$10 copay	First 15 visits: 80% coverage of the allowed amount Visits 16 and over: 50% 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	First 4 visits: no copay Visits 5 and over: \$10 copay	First 15 visits: 80% coverage of the allowed amount Visits 16 and over: 50% coverage of the allowed amount Subject to deductible.

¹ You must obtain prior authorization for most inpatient, intermediate and hospital care. Please see Table 10, "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 9. Mental Health, Substance Use Disorder, and EAP Benefits for Medicare Members (continued)

Covered Services	In-Network Benefits	Out-of-Network Benefits
Outpatient Care – Mental Health, Substance Use Disorder and Enrollee Assistance Program (continued)		
<p>Group Therapy, all types Includes Autism Spectrum Disorder group therapy visits</p>	<p>First 4 visits: no copay Visits 5 and over: \$5 copay</p>	<p>First 15 visits: 80% coverage of the allowed amount Visits 16 and over: 50% coverage of the allowed amount Subject to deductible.</p>
<p>Medication Management 15 to 30-minute psychiatrist visit)</p>	<p>First 4 visits: no copay Visits 5 and over: \$5 copay</p>	<p>First 15 visits: 80% coverage of the allowed amount Visits 16 and over: 50% coverage of the allowed amount Subject to deductible.</p>
<p>Urine Drug Screening In conjunction with in-network substance use disorder treatment</p>	<p>100% coverage</p>	<p>No coverage</p>
<p>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.</p>		
<p>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.</p>	<p>Counseling: Up to 4 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:</p> <ul style="list-style-type: none"> ▪ 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 <p>Child and elder care: access to referrals in your area Domestic violence resources: access to a confidential hotline and supportive services</p>	<p>No coverage</p>

PART 3: Behavioral Health Plan

What This Plan Pays: Summary of Covered Services

The Plan pays for the services listed in Table 10. All services must either be covered by Medicare or meet Beacon’s medical necessity criteria to be approved.

Note: Beacon does not require authorization if you are receiving a Medicare covered service from a Medicare participating provider. *The below authorization requirements apply only to services not covered by Medicare.*

Table 10. Summary of Covered Services¹

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 123). Failure to obtain prior authorization, when required, may result in no coverage.

Table 10. 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) <i>In conjunction with substance use disorder treatment</i>	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.

PART 3:
Behavioral Health Plan

¹ These services are subject to certain exclusions, which can be found in “What’s Not Covered – Exclusions” (page 123). Failure to obtain prior authorization, when required, may result in no coverage.

Table 10. 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 123). Failure to obtain prior authorization, when required, may result in no coverage.

Table 10. 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 80% of the allowed amount for your first 15 visits. Visits 16 and over are paid at 50% of the allowed amount. 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 123). 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 services, if they are not covered by Medicare.* 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 126) 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 ABA services, if they are not covered by Medicare.* 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 if not covered by Medicare*)
 - Partial Hospitalization/Day Treatment (*prior authorization required if not covered by Medicare*)
 - Intensive Outpatient Treatment (*prior authorization required if not covered by Medicare*)
 - Services at an Acute Residential Treatment Facility (*prior authorization required if not covered by Medicare*)
 - 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 if not covered by Medicare*)

Psychological/Neuropsychological Testing

You must obtain prior authorization for psychological testing, if it is not covered by Medicare.

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, if it is not covered by Medicare. 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 \$50 copay per quarter. The copay is waived if you are readmitted within 30 days of discharge.

Out-of-network intermediate care is paid at 80% of the allowed amount, after a \$150 copay per quarter. Out-of-network intermediate care is subject to the deductible.

You or your provider must obtain prior authorization for intermediate care, if it is not covered by Medicare. 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 \$50 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 80% of the allowed amount, after a \$150 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, if it is not covered by Medicare. 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 four 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.

Coinsurance – The amount you pay for certain services under Beacon. The amount of coinsurance is a percentage of the total amount for the service; the remaining percentage is paid by Beacon. The provider is responsible for billing the member for the remaining percentage.

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 January 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 coinsurance, 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 beaconhealtoptions.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: Privacy Notices

Appendix C: Interpreting and Translating Services

Appendix D: Forms

Appendix E: Federal and State Mandates

Appendix F: Your Right to Appeal

Appendix A: GIC Notices

- ❑ Important Notice from the GIC about Your Prescription Drug Coverage and Medicare
- ❑ The Uniformed Services Employment and Reemployment Rights Act (USERRA)

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/Medicare Extension 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 SilverScript plan. If you are disenrolled from SilverScript, 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](https://www.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 19 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](https://www.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](https://www.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.

Appendix B: Privacy Notices

- ❑ UniCare's HIPAA Notice of Privacy Practices
- ❑ Maine Notice of Additional Privacy Rights

UniCare's HIPAA Notice of Privacy Practices

Effective January 1, 2015

State notice of privacy practices

As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your personal information

We may collect, use and share your non-public personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company – without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity. You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you. A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

HIPAA notice of privacy practices

THIS NOTICE DESCRIBES HOW HEALTH, VISION AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information (PHI)

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan.

For health care operations: We use and share PHI for health care operations.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. **Examples of ways we use your information for payment, treatment and health care operations:**

- We keep information about your deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your health care provider so that the provider may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.
- We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations and treatment. If you do not want your PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit anthem.com/health-insurance/about-us/privacy for more information.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: In most cases, if we use or disclose your PHI outside of treatment, payment, operations or research activities, we must get your OK in writing first. We must receive your written OK before we can use your PHI for certain marketing activities. We must get your written OK before we sell your PHI. If we have them, we must get your OK before we disclose your provider's psychotherapy notes. Other uses and disclosures of your PHI not mentioned in this notice may also require your written OK. You always have the right to revoke any written OK you provide.

You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI for other types of activities, including:

- Health oversight activities
- Judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents)
- Organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety
- Special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes
- As required by law

If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. If your employer pays your premium or part of your premium, but does not pay your health insurance claims, your employer is not allowed to receive your PHI – unless your employer promises to protect your PHI and makes sure the PHI will be used for legal reasons only.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic information: We cannot use or disclose PHI that is an individual’s genetic information for underwriting.

Your rights

Under federal law, you have the right to:

- ❑ Send us a written request to see or get a copy of certain PHI, or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- ❑ Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- ❑ Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- ❑ Send us a written request to ask us for a list of certain disclosures of your PHI. Call UniCare Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.
- ❑ Right to a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or disclosure of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to UniCare, UniCare does not have to agree to a restriction (see “Your rights”, above). If a law requires the disclosure, UniCare does not have to agree to your restriction.

How we protect information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure.

We have to keep your PHI private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law and outlined in this notice.

Potential impact of other applicable laws

HIPAA (the federal privacy law) generally does not preempt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Contacting you

We, including our affiliates or vendors, may call or text any telephone numbers provided by you using an automated telephone dialing system and/or a prerecorded message. Without limitation, these calls may concern treatment options, other health-related benefits and services, enrollment, payment, or billing.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact information

Please call UniCare Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Effective date of this notice

The original effective date of this Notice was April 14, 2003. The most recent revision date is indicated on the first page of this Notice.

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.

This Notice is provided by the following company:



UniCare Life & Health Insurance Company

Maine Notice of Additional Privacy Rights

The Maine Insurance Information and Privacy Protection Act provides consumers in Maine with the following additional rights.

- ❑ The right:
 - To obtain access to the consumer’s recorded personal information in the possession or control of a regulated insurance entity,
 - To request correction if the consumer believes the information to be inaccurate, and
- ❑ To add a rebuttal statement to the file if there is a dispute;
- ❑ The right to know the reasons for an adverse underwriting decision (previous adverse underwriting decisions may not be used as the basis for subsequent underwriting decisions unless the carrier makes an independent evaluation of the underlying facts); and
- ❑ The right, with very narrow exceptions, not to be subjected to pretext interviews.

Appendix C: Interpreting and Translating Services

If you need a language interpreter when you contact the UniCare Customer Service Center, 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 TDD machine, you can contact the UniCare State Indemnity Plan by calling its telecommunications device for the deaf (TDD) line at 800-322-9161 or 978-474-5163.

Servicios de interpretación y traducción

Si usted necesita un intérprete de su idioma para comunicarse con el UniCare Customer Service Center, el representante de atención al cliente que le atiende a usted se pondrá en contacto telefónico con un intérprete, el cual traducirá lo que ambos digan y hará posible su conversación con dicho representante. Si usted es sordo o duro de oído y tiene una máquina TDD, póngase en contacto con el UniCare State Indemnity Plan llamando a su línea TDD de telecomunicaciones para sordos: 800-322-9161 ó 978-474-5163.

Serviços de Interpretação e Tradução

Se você precisar de um intérprete para uma outra língua quando você entrar em contato com o UniCare Customer Service Center, um representante do serviço ao consumidor irá acessar uma linha de línguas e conectá-lo com um intérprete que irá traduzir sua conversa com o representante. Se você for surdo ou tiver dificuldade para escutar e tiver uma máquina de TDD, você pode contactar o UniCare State Indemnity Plan telefonando para a linha do seu dispositivo de telecomunicações para os surdos (TDD) no número 800-322-9161 ou 978-474-5163.

Services de traduction et d'interprétation

Si vous avez besoin d'un interprète lorsque vous contactez le UniCare Customer Service Center, un représentant du service clientèle se connectera alors à un service d'interprétation par téléphone et vous mettra en relation avec un interprète qui traduira votre conversation. Si vous êtes sourd ou malentendant et que vous possédez un appareil TDD (Telecommunications Device for the Deaf, appareil de télécommunication pur sourds et malentendants), vous pouvez contacter le UniCare State Indemnity Plan en appelant leur service TDD au 800-322-9161 ou 978-474-5163.

Servizi di traduzione e interpretazione

Se avete bisogno di un interprete quando prendete contatto con il UniCare Customer Service Center, un rappresentante servizio clienti si metterà allora in linea con il servizio d'interpretazione e vi metterà in relazione con un interprete che farà la traduzione della vostra conversazione. Se debole d'udito o sordo e possedete un apparecchio TDD (dispositivo Telecomunicazioni per sordi) potete prendere contatto con il UniCare State Indemnity Plan telefonando al loro servizio TDD al 800-322-9161 o al 978-474-5163.

Sèvis Entèprèt

Si w bezwen yon entèprèt pou lang lè w kontakte UniCare Customer Service Center, yon reprezantan sèvis kliyantèl la pral kontakte yon liy pou lang, epi lap kontekte w ak yon entèprète kí pral tradwi konvèsasyon w ak reprezantan an. Si w pa kapab tande byen, epi ou gen yon machin TDD, ou ka kontakte UniCare State Indemnity Plan si w rele nimewo aparèy telekomunikasyon pou moun soud la (TDD), ki se 800-322-9161 oswa 978-474-5163.

口笔译服务

如果您联系Andover（安多佛）服务中心时需要口译，客户服务代表会接通一条语言专线，为您联系一名口译员来翻译您与服务代表之间的对话。如果您失聪或有听力困难而且使用TDD机，您可以与UniCare州保障计划处联系，拨打他们的听力障碍者专用通讯设备电话（TDD）：(800) 322-9161或(978) 474-5163

Υπηρεσίες Μετάφρασης και Διερμηνείας

Αν χρειάζεστε μεταφραστή ή γλώσσα όταν επικοινωνείτε με το Κέντρο Εξυπηρέτησης του Andover, ένας αντιπρόσωπος εξυπηρέτησης πελατών θα σας συνδέσει με ένα διερμηνέα μέσω τηλεφωνικής γραμμής, και αυτός θα μεταφράσει τη συζήτησή σας με τον αντιπρόσωπο. Αν είστε κωφάλαλος ή πάσχετε από βαρηκοΐα και έχετε μηχανή ΤΣΚ, μπορείτε να επικοινωνήσετε με το Πρόγραμμα Αποζημίωσης UniCare της Πολιτείας τηλεφωνώντας στη γραμμή που είναι συμβατή με την τηλεπικοινωνιακή συσκευή για κωφούς (ΤΣΚ) στο (800) 322-9161 ή στο (978) 474-5163.

សេវាកម្មបកប្រែផ្ទាល់មាត់ និងឯកសារ

បើលោក-អ្នកត្រូវការអ្នកបកប្រែភាសាម្នាក់នៅពេលលោក-អ្នកទាក់ទងទៅមន្ទីរសេវាកម្មអែនដេមីតឺ(Andover Service Center) តំណាងសេវាកម្មអតិថិជននឹងប្រើប្រាស់ខ្សែភាសាហើយតភ្ជាប់លោក-អ្នកជាមួយអ្នកបកប្រែម្នាក់ដែលនឹងបកប្រែកិច្ចសន្ទនារបស់លោក-អ្នកជាមួយអ្នកតំណាងនោះ។ បើសិនជាលោក-អ្នកចង់ ឬក៏មានការលំបាកក្នុងការស្តាប់ និងមានម៉ាស៊ីន TDD លោក-អ្នកអាចទាក់ទងទៅយូនីមែរី ស្តេត អ៊ីនឌីមេនីតឺ ផ្លែន(UniCare State Indemnity Plan) ដោយទូរស័ព្ទទៅឧបករណ៍សំរាប់ទាក់ទងសំរាប់មនុស្សច្រឡំ (TDD)របស់គេនៅខ្សែលេខ (800) 322-9161 ឬ (978) 474-5163 ។

خدمات الترجمة

إذا احتاجت إلى مترجم لغات عند اتصالك بمركز خدمة ندوفر Andover Service Center، فإن مندوب خدمة لعملاء سوف يقوم بالاتصال بخط اللغات ويوصلك مترجم سيقوم بترجمة محادثتك مع المندوب. إذا كنت صم أو تعاني من ضعف في السمع ولديك جهاز TDD، يمكنك الاتصال بخطة ضمان يونيكير UniCare State Indemnity Plan عن طريق إجراء اتصال بخط لاتصالات للصم (TDD) على الرقم (800) 322-9161 و (978) 474-5163 .

ສູນບໍລິການແປພາສາ

ຖ້າທ່ານຕ້ອງການຜູ້ແປພາສາ ໃຫ້ທ່ານຕິດຕໍ່ກັບ ສູນບໍລິການແອນໂດເວີ ຜູ້ຕາງໜ້າສູນໃຫ້ບໍລິການ ລູກຄ້າ ຈະສົ່ງເຂົ້າສາຍພາສາ ແລະຕໍ່ສາຍຂອງທ່ານ ກັບຜູ້ແປພາສາ ຊຶ່ງຈະເປັນຜູ້ແປການສົນທະນາຂອງ ທ່ານກັບຜູ້ຕາງໜ້າ. ຖ້າທ່ານຫຼຸໜວກ ຫຼືຟັງຍາກ ແລະ ມີເຄື່ອງຊ່ວຍຟັງ (TDD), ທ່ານສາມາດຕິດຕໍ່ກັບ ໂຄງການເງິນຊົດເຊີຍຂອງ ລູນິແຄ ສເຕທ ໂດຍໂທລະສັບໄປທີ່ (TDD), ໄດ້ທີ່ເບີ (800) 322-9161 ຫຼື (978) 474-5163.

Услуги Устного и Письменного Перевода
Если Вам нужны услуги переводчика, когда Вы звоните в Центр услуг Андовера, специалист по работе с клиентами соединит Вас с переводчиком, который переведёт Ваш разговор. Если Вы глухи или имеете нарушения слуха и TDD устройство, Вы можете связаться с программой «UniCare State Indemnity Plan», позвонив на специальную линию для глухих (TDD) по номеру (800) 322-9161 или (978) 474-5163.



Appendix D: Forms

This appendix contains the following forms:

- Fitness Club Reimbursement Form

 You can download this 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 38 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

Appendix E: 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.flmedicaidtprecovery.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. 61565¹

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 F: Your Right to Appeal

The following procedures describe how the Plan handles member inquiries, complaints and grievances/appeals.

Inquiry Process

The Plan provides a process for responding to inquiries. An **inquiry** is any communication by you or your authorized representative to the Plan that has not been the subject of an adverse determination and that requests redress of an action, omission or policy of the Plan. An adverse determination is a determination by the Plan, based upon a review of information, to deny, reduce, modify or terminate a hospital admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity; appropriateness of health care setting and level of care; or effectiveness, including a determination that a requested or recommended health care service or treatment is experimental or investigational.

The Plan maintains records of each member inquiry, and the Plan's response to the inquiry, for a period of two years. These records are subject to inspection by the Massachusetts Commissioner of Insurance and the Office of Patient Protection.

Grievances/Appeals Process

If your inquiry has not been explained or resolved to your satisfaction within three business days of the inquiry, you have the option of having it reviewed as a complaint through the internal grievance process. A **complaint** is either an inquiry made by you or your authorized representative to the Plan that is not explained or resolved to your satisfaction within three business days of the inquiry, or a matter involving an adverse determination.

The Plan will provide you with a written notice that describes your right to have your complaint processed as a grievance/appeal. To initiate a grievance/appeal, contact the Plan at 800-442-9300, or send the grievance/appeal to the Plan in writing. For assistance in resolving grievances/appeals with the UniCare State Indemnity Plan, call the Office of Patient Protection at 800-436-7757.

A **grievance/appeal** is any verbal or written complaint submitted to the Plan that has been initiated by you or your authorized representative regarding any aspect or action of the Plan relative to you including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services, quality of care and administrative operations.

Your request to initiate the grievance/appeal process should be made within 180 days of the Plan's notification to you that you have the right to have your complaint processed as a grievance/appeal. Your request should state why you believe the Plan did not resolve your complaint to your satisfaction or, in the case of an adverse determination, why you believe the determination was in conflict with Plan provisions. You should include all supporting documentation (at your own expense).

The Plan will provide you, or your authorized representative, with a written acknowledgment of the receipt of a grievance/appeal within 15 business days of its receipt of your grievance/appeal, whether it is received in writing or verbally through UniCare Customer Service. UniCare will provide you, or your authorized representative, with a written resolution of your grievance/appeal within 30 business days of receipt of the verbal or written grievance/appeal. See "Time Requirements for Resolution of Grievances/Appeals" below.

Any grievance/appeal filed that requires the review of medical records must contain your written signature, or that of your authorized representative, on a form provided by the Plan. This form authorizes the release of medical and treatment information relevant to the grievance/appeal submitted to the Plan, when necessary, in a manner consistent with state and federal law. The Plan will request this authorization from you when necessary for grievances/appeals received through UniCare Customer Service, or for any written grievances/appeals that lack this authorization. You or your authorized representative will have access to any medical information and records relevant to your grievance/appeal that is in the possession of the Plan and under its control.

Time Requirements for Resolution of Grievances/Appeals

The Plan will provide you, or your authorized representative, with a written resolution of a grievance/appeal that does not require the review of medical records, within 30 business days of receipt of the verbal or written grievance/appeal. The 30 business day time period for written resolution of a grievance/appeal begins:

- On the day immediately following the three business day time period for processing inquiries, if the inquiry has not been addressed within that period of time, or
- On the day you or your authorized representative notify the Plan that you are not satisfied with the response to an inquiry

The time limits specified above may be waived or extended by mutual written agreement between you, or your authorized representative, and the Plan. Any such agreement will state the additional time limits, which shall not exceed 30 business days from the date of the agreement.

When a grievance/appeal requires the review of medical records, the 30 business day period will not begin until you or your authorized representative submits a signed authorization for release of medical records and treatment information.

If the signed authorization is not provided by you or your authorized representative within 30 business days of the receipt of the grievance/appeal, the Plan may, at its discretion, issue a resolution of the grievance/appeal without review of some or all of the medical records.

A grievance/appeal not properly acted on by the Plan within the time limits will be deemed resolved in your favor. Time limits include any extensions made by mutual written agreement between the Plan and you or your authorized representative.

Grievances/appeals will be reviewed by an individual or individuals who are knowledgeable about the matters at issue in the grievance/appeal. Grievances/appeals of adverse determinations will be reviewed with the participation of an individual or individuals who did not participate in any of the Plan's prior decisions on the grievance/appeal. For the review of grievances/appeals of adverse determinations involving medical necessity, the reviewers will have included actively practicing health care professionals in the same or similar specialty who typically treat the medical condition, perform the procedure or provide the treatment that is the subject of the grievance/appeal.

In the case of a grievance/appeal that involves an adverse determination, the written resolution will include a substantive clinical justification that is consistent with generally-accepted principles of professional medical practice, and will, at a minimum:

- Identify the specific information upon which the adverse determination was based
- Discuss your presenting symptoms or condition, diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria

- Specify alternative treatment options covered by the Plan, if any
- Reference and include applicable clinical practice guidelines and review criteria, and
- Notify you or your authorized representative of the procedures for requesting external review, including the procedures to request an expedited external review

The Plan offers the opportunity to reopen a grievance/appeal about a final adverse determination when the relevant medical information was:

1. Received too late to review within the 30 business day time limit, or
2. Not received but is expected to become available within a reasonable time period following the written resolution

When you or your authorized representative request that a grievance/appeal about a final adverse determination be reopened and the Plan agrees with the request to reopen the grievance/appeal, the Plan will agree in writing to a new time period for review. However, in no event will this new time period be greater than 30 business days from the date of the agreement to reopen the grievance/appeal. The time period for requesting external review will begin on the date of the resolution of the reopened grievance/appeal.

Expedited Grievance/Appeal Process

An expedited grievance/appeal process is available for grievances/appeals concerning services, including durable medical equipment, that are needed on an immediate or urgent basis. If the issue involves ongoing inpatient hospital services, services to the terminally ill, or a case where delay could result in serious jeopardy to your life or health, the grievance/appeal may be handled through the expedited grievance/appeal process. This expedited process will be completed as follows:

- A written resolution will be provided prior to the date of discharge if the grievance/appeal is submitted by you during a period of ongoing hospitalization services. If the expedited review process results in an adverse determination regarding the continuation of inpatient care, the written resolution must inform you, or your authorized representative, of your right to request an expedited external review and your right to request continuation of inpatient services.
- A resolution of the grievance/appeal will be provided to you or your authorized representative within five business days of receipt of the grievance/appeal if you have a terminal illness.
- When a grievance is submitted by a member with a terminal illness, a resolution will be provided to you, or your authorized representative, within five business days from the receipt of such grievance, except that grievances regarding urgently needed services shall be resolved within 72 hours. If the expedited review process affirms the denial of your or your dependent's coverage or treatment and you or your dependent have a terminal illness, the Plan will provide you, or your authorized representative, within five business days of the decision with a:
 - Statement setting forth the specific medical and scientific reasons for denying coverage or treatment
 - Description of alternative treatment, services or supplies covered or provided by the Plan, if any

In addition, you and/or your authorized representative have the right to have a conference with the Plan within five to 10 days of your request for a conference to discuss the resolution. The conference will be scheduled within 10 days of receiving your request. However, the conference will be held within five business days of the request if the treating physician determines, after consultation with the Plan’s medical director or his/her designee, and based on standard medical practice, that the effectiveness of either the proposed treatment, services or supplies or any alternative treatment, services or supplies covered by the Plan, would be materially reduced if not provided at the earliest possible date.

Decisions will be provided within 48 hours for denials involving services or durable medical equipment if denial for such services or equipment will create a substantial risk of serious harm.

If a grievance is filed concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment will remain in effect at the Plan’s expense through completion of the grievance process, regardless of the final grievance decision. The ongoing coverage or treatment includes only that medical care that, at the time it was initiated, was authorized by the Plan.

How to File an Inquiry, Complaint or Grievance/Appeal

The Plan allows you to initiate an inquiry, complaint or grievance/appeal in the following ways:

1. **By mail** – For requests relating to the review process (inpatient hospital admissions; certain outpatient diagnostic and surgical procedures; durable medical equipment; home health care; physical and occupational therapy; and chiropractic and osteopathic manipulation), direct the request to:

UniCare State Indemnity Plan
 Appeals Review
 P.O. Box 2011
 Andover, MA 01810-0035

Send all other requests to:

UniCare State Indemnity Plan
 Appeals Review
 P.O. Box 2075
 Andover, MA 01810-0037

2. **By fax** – Fax a written request to the Plan at 800-848-3623.
3. **By telephone** – Call the Plan at 800-442-9300 to submit your request verbally to a customer service representative.
4. **In person** – Submit your request to the Plan in person at the following address:

UniCare
 300 Brickstone Square, 8th Floor
 Andover, MA 01810

External Review Process

Grievances/appeals involving coverage decisions based on medical necessity and rescissions that are not resolved to your satisfaction after completion of the Plan's grievance/appeal process may be eligible for an independent external review through the Massachusetts Health Policy Commission's Office of Patient Protection (OPP).

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.

You must file your request with OPP within four months of your written receipt of the adverse determination. OPP facilitates the external review process. To obtain the necessary forms, you must contact OPP at 800-436-7757, or access its website at mass.gov/dph/opp.

Expedited External Review Process

While still an inpatient, you may request an expedited external review of an adverse determination if the treating physician certifies, in writing, that delay in the continuation of the inpatient services would pose a serious and immediate threat to your health. You may also request continuation of services if the subject matter of the external review involves the termination of ongoing services. Under these circumstances, you may apply to the external review panel to seek the continuation of coverage for the terminated service for the period in which the review is pending. The review panel may order the continuation of coverage or treatment where it determines that substantial harm to your health may result unless the services are continued, or for such other good cause as the review panel shall determine. Any such continuation of coverage shall be at the Plan's expense, regardless of the final external review determination. The expedited review decision will be issued within five business days.

If a grievance/appeal is filed concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment will remain in effect at the Plan's expense through completion of the grievance/appeal process, regardless of the final grievance/appeal decision. Ongoing coverage or treatment includes only that medical care that, at the time it was initiated, was authorized by the Plan and does not include medical care that was terminated pursuant to a specific time or episode-related exclusion from your contract for benefits.

If the subject matter of the external review involves the termination of ongoing services, you may apply to the external review panel to seek the continuation of coverage for the terminated service during the period in which the review is pending. Any such request must be made before the end of the second business day following receipt of the final adverse determination. The review panel may order the continuation of coverage or treatment where it determines that substantial harm to your health may result without such continuation, or for such other good cause as the review panel shall determine. Any such continuation of coverage shall be at the Plan's expense, regardless of the final external review determination.

You must submit requests for external review on a form provided by the Massachusetts Office of Patient Protection (OPP). Sign the form consenting to the release of medical information and include a copy of the written final adverse determination issued by the Plan. Also include a check for \$25 to cover OPP's review. OPP may waive this fee if it would result in an extreme financial hardship to you.

Index

The pages shown in boldface have the most complete information.

0-9

24/7 NurseLine.....3, 87, **89**

A

Acne-related services **63**
Acupuncture..... **63**
Adverse determinations **46**, 91
Air conditioners **67**
Allowed amount..... **19**, 91
Ambulance services 22, **27**, **63**
Ambulatory surgery centers..... **91**
Ancillary services..... **44**
Anesthesia..... **27**, **63**
Appeals 74, 92, **Appendix F**
Arch supports..... **63**
Assistant surgeons..... **55**, **63**
Athletic trainers..... **63**
Audiology services.....see *Hearing exams*
Autism spectrum disorders **27**
.....also see *Behavioral health services*

B

Balance billing **19**, 91
Beacon Health Options3, 13, 87, **107-131**
Beds **63**, **67**
Behavioral health, definition of **27**, 91
Behavioral health services22, 27, 63, **107-131**
Benefits summary **22-26**
Bereavement counselingsee *Hospice care*
Birth control..... see *Family planning*
Blood donations **64**
Blood pressure cuff..... **64**
Bone density testing..... **61**
Bone marrow transplants **57**
Braces.....see *Orthotics*
BRCA testing..... **59**

Breast cancer

and bone marrow transplants **57**
prosthetics **53**
screening **59**
surgery **55**, 149

C

Calendar quarter, definition of **17**
Cardiac rehabilitation 22, **28**
Case management..... **75**
CAT scans see *High-tech imaging*
Cataracts see *Eye care*
Chair cars / vans **64**
Checkups **59-62**
Chemotherapy 22, **28**
Children’s Health Insurance Program
(CHIP)..... **146-148**
Chiropractic care 22, **28**, **66**
Cholesterol screening **59**
Chronic disease facilities
..... see *Other inpatient facilities*
CIC 12, **91**
Circumcision **28**
Claims
checking claim status **90**
claims review **73**
deadline for filing **73**
denial of 46, **75**, **Appendix F**
how processed..... **72**
legal action..... **73**
requesting a review **90**
submitting **72**
Cleft lip / cleft palate..... **29**
Clinical trials **29-30**, **64**
Clinics see *Medical clinics*
COB..... see *Coordination of Benefits*
COBRA **80-83**
Cognitive therapy **64**
Coinsurance..... **17**, 91

Colonoscopies..... **60, 64**
 Commodes **67**
 Comprehensive Insurance Coveragesee *CIC*
 Computer-assisted communications devices ... **64**
 Contact information..... **3, 87**
 Contact lenses.....see *Eyeglasses*
 Continued stay review **46**
 Contract suppliers (Medicare)
 see *Preferred vendors*
 Coordination of Benefits (COB)..... **84-86**
 Copays **17, 91**
 Cosmetic services **64, 92**
 Costs see *Member costs*
 Coverage information..... **76-86**
 application for coverage..... **76**
 COBRA..... **80-83**
 continuing **78-80**
 special enrollment condition..... **78**
 termination..... **77**
 Craniosacral therapy....see *Manipulative therapy*
 CT scans see *High-tech imaging*
 Custodial care **64, 92**
 Customer Service Center **3, 14, 87, 88**

D

Deductible..... **16, 92**
 Definitions of terms **91-95**
 Dental services..... **30-31, 64**
 Dentures..... **64**
 Dependent, definition of..... **92**
 Designated hospitals..... **58**
 Diabetes care **31, 60**
 Diabetes supplies **22, 32**
 Diagnostic lab tests..... see *Laboratory services*
 Dialysis..... **22, 33**
 Dietary counseling..... see *Nutritional counseling*
 Disclosure when plan
 meets minimum standards..... **2**
 Disenrollment **74, 77**
 Divorce **78-80**
 Doctor services **22, 33**
 Documents.....see *Plan materials*
 Driving evaluations **64**
 Drugs see *Prescription drugs*
 Durable medical equipment (DME)
 **15, 21, 22, 33-35, 40, 67**

E

EAP (Enrollee Assistance Program)..... **107-131**
 Ear molds **64**
 Early intervention programs **23, 35**
 EKG (electrocardiogram)..... **64**
 Elective services **15, 92**
 Eligibilitysee *Coverage information*
 Email consultations..... **65**
 Emergency, definition of **35**
 Emergency room services **15, 17, 23, 35**
 Enrolled providers (Medicare)..... **20**
 Enrollee, definition of..... **92**
 Enrollmentsee *Coverage information*
 Enteral therapy..... **15, 36, 65**
 Excluded services **63-69**
 Experimental procedures **65, 66, 92**
 Eye care..... **17, 23, 36, 62, 66, 68**
 Eyeglasses..... **23, 37, 65**

F

Family planning..... **23, 37**
 Filing deadlinesee *Claims*
 Fitness reimbursement **23, 38, 65, 145**
 Food products **39**
 Foot care **38, 63**
 Forms **Appendix D**
 Formulas, special **39**
 Free or low-cost coverage..... **65, 76**

G

Gender reassignment surgery..... **15**
 Grievance, definition of **92**
 Grievance process see *Appeals*
 Gyms..... see *Fitness reimbursement*
 Gynecology exams..... **39, 59, 60**

H

Hearing aids **23, 39-40**
 Health insurance, definition of..... **92**
 Hearing exams **23, 40, 60**
 High-tech imaging **48**
 HIPAA see *Privacy rights*
 Hippotherapy **66**
 Home construction..... **66**
 Home health care **15, 23, 40-41**
 Home infusion therapy..... **23, 41**

Hormone replacement..... see *Family planning*
 Hospice care..... 23, **42-43**
 Hospital, inpatient
 see *Inpatient care at hospitals*
 Hospitals **71**, 93

I

ID cards..... **14**, 70
 Imagingsee *Radiology services*
 Immunizations..... 58, **60**, 66
 IMRT **53**
 Incontinence supplies..... **66**
 Infertility treatment..... **43-44**, 66
 Injury, definition of..... **93**
 Inpatient care at hospitals.... 15, 17, 24, **44-46**, 93
 Inpatient care at other facilities..... 24, **47**
 Inquiry, definition of..... **93**
 Insurance, other..... **13**
 Internet services **69**
 Interpreting services..... **2**
 In vitro fertilization..... see *Infertility treatment*

L

Laboratory services..... 24, **48**, 62
 Language interpretersee *Interpreting services*
 Legal action..... **73**
 Lenses, intraocular **66**
 Lift chairs..... **66**
 Limited services..... **63-69**
 Long-term care..... **66**
 Long-term care facilities
 see *Other inpatient facilities*
 Low-cost coverage
 see *Free or low-cost coverage*

M

Mammograms **59**
 Manipulative therapy **51**, 66
 Massage **66**
 Maternity benefits 15, **48**, 149
 Mattresses, orthopedic **67**
 Medical clinics..... 24, **48**, 71
 Medical necessity..... 66, **93**
 Medical services, other 24, **49**
 Medical supplies **93**

Medicare
 contract suppliers..... see *Preferred vendors*
 and Medicare Extension plan..... **18**
 membership **12**
 and prescription drugs **134-136**
 providers **20**, 70, 71
 Medicare Extension plan
 description of..... **12**
 enrollment and membership **76-86**
 and Medicare **18**
 Member costs **16-21**, 70
 Member, definition of **94**
 Mental health services
 see *Behavioral health services*
 Molding helmets..... **67**
 MRIs..... see *High-tech imaging*

N

Non-CICsee *CIC*
 Non-Massachusetts providerssee *Providers*
 Non-participating providers (Medicare)..... **20**
 Notice of privacy practices
 see *Privacy rights*
 Notification requirements..... **14-15**, 70
 Nurse practitionerssee *Providers*
 Nursing homes, definition of..... **94**
 NurseLine.....see *24/7 NurseLine*
 Nutritional counseling..... **49**, 60, 67
 Nutritional supplements **67**

O

Occupational injury..... **69**
 Occupational therapy..... 24, **49**, 65
 Office of Patient Protection..... 74, **90**
 Office visits 17, 24, **33**
 Online access to plan information..... **89**
 Organ donors.....see *57*
 Orthodontic treatment **67**
 Orthotics 25, **53**, 67
 Osteopathic care see *Chiropractic care*
 Other health insurance..... **13**
 Other inpatient facilities..... 24, **47**, 94, 95
 Out-of-pocket limit..... **18**, 94
 Out-of-state providerssee *Providers*
 Outpatient services 24, **50**
 Outpatient surgery..... 26, **54-56**
 Oxygen 25, 34, **50**, 67

P

Palliative care 50
 Pap smear 39, 59
 Participating providers (Medicare) 20, 70, 71
 Patient protection
 see *Office of Patient Protection*
 Patients' Bill of Rights 90
 PCPs (primary care providers) see *Providers*
 Personal comfort items 67
 Personal Emergency
 Response Systems (PERS) 25, 51
 PET scans see *High-tech imaging*
 Physical therapy 25, 51, 65
 Physician assistants see *Providers*
 Physician, definition of 94
 Physician services see *Doctor services*
 Plan definitions 91-95
 Plan materials 89
 Post-delivery care, home 149
 Preferred vendors 21, 70, 71, 94, 95
 Prescription drugs
 coverage for 25, 52, 64, 97-106
 and Medicare 134-136
 Pre-service review 14, 74
 Preventive care 25, 52, 59-62
 Primary care providers (PCPs) see *Providers*
 Privacy rights 74, **Appendix B**
 Private contracts (Medicare) 20
 Private duty nursing 15, 25, 52-53
 Private room 44
 Prosthetics 25, 53
 Providers
 finding 72, 89
 in Massachusetts 19
 Medicare 20, 70, 71
 nurse practitioners 94
 outside of Massachusetts 19
 PCPs 71
 physician assistants 94
 reimbursement of 19, 72
 services 22, 33
 specialists 71
 types of 20, 71
 PSA test 61

Q

Qualified clinical trials see *Clinical trials*
 Quality Centers for transplants
 see *Designated hospitals*
 Quarter see *Calendar quarter*

R

Radiation therapy 26, 53
 Radioactive isotope therapy 53
 Radiology services 24, 48
 Reconsideration (after a denial) 75
 Reconstructive surgery 55, 149
 Rehabilitation services, definition of 95
 Release of medical information 90
 Religious facilities, use of 67
 Reporting requirements 74
 Respite care 42, 68
 Retail medical clinics see *Medical clinics*
 Reviews of medical services 14, 74
 Right of recovery 86
 Right of reimbursement 73
 Routine screenings 68

S

Sensory integration therapy 68
 Shower chairs 67
 SilverScript 3, 13, 87, 97-106
 Skilled care, definition of 95
 Skilled nursing facilities
 see *Other inpatient facilities*
 Sleep studies 54
 Smoking see *Tobacco cessation*
 Special enrollment condition 78
 Specialists see *Providers*
 Speech therapy 26, 54, 66
 Spouse, definition of 95
 Stairway lifts / ramps 68
 Students 92
 Sub-acute care facilities
 see *Other inpatient facilities*
 Substance use disorder services
 see *Behavioral health services*
 Summary of benefits 22-26
 Surface electromyography (SEMG) 68
 Surgery 26, 54-56
 Surrogates 66
 Symbols, in handbook 13

T

Telecommunications device for the deaf (TDD).....	3
Telehealth.....	68
Telephone consultations.....	68
Telephone numbers, important	3
Terminal illness, definition of.....	42
Termination of coverage	77
Thermal therapy devices	68
TMJ disorder.....	68
Tobacco cessation.....	26, 56, 68
Transitional care facilitiessee <i>Other inpatient facilities</i>	
Translating services	see <i>Interpreting services</i>
Transplants.....	15, 26, 57-58
Travel clinics.....	58

U

unicarestateplan.com.....	88-89
UniCare Customer Service Center... 3, 14, 87, 88	
Urgent care.....	48
Urgent care centers	see <i>Medical clinics</i>
USERRA (Uniformed Services Employment and Reemployment Rights Act).....	136

V

Vision care	see <i>Eye care</i>
Visiting Nurse Associations (VNA).....	40, 95
Voice therapy	69

W

Walk-in clinics	see <i>Medical clinics</i>
Website.....	see <i>unicarestateplan.com</i>
Weight loss programs.....	69
Whirlpools.....	67
Wigs	58, 69
Workers compensation.....	69
Worksite evaluations	69

X

X-rays.....	see <i>Radiology services</i>
-------------	-------------------------------



UniCare State Indemnity Plan
P.O. Box 9016
Andover, MA 01810-0916
800-442-9300
unicarestaateplan.com