SERIES 4

UNICARE STATE INDEMNITY PLAN

PLUS

Member handbook for active employees and Non-Medicare retirees

Effective July 1, 2021

UniCare℠

Commonwealth of Massachusetts
Group Insurance Commission

UNICARE STATE INDEMNITY PLAN/PLUS MEMBER HANDBOOK

For active employees and non-Medicare retirees

Effective July 1, 2021

UniCare℠

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 (https://mahealthconnector.optum.com/individual/).

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, 2018. 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 www.mass.gov/orgs/division-of-insurance.

Interpreting and Translating Services

If you need a language interpreter when you call Member Services, a UniCare health guide will access a language line and connect you with an interpreter who will translate your conversation with the health guide.

If you use a TTY machine, you can reach UniCare by calling 711.

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.

Whom to Contact

Questions about medical or behavioral health coverage	
UniCare State Indemnity Plan P.O. Box 9016 Andover, MA 01810-0916 ▪ **Member Services:** 833-663-4176 / TTY: 711 (toll free) 8:00 a.m. to 8:00 p.m. (M-F) ▪ **Email:** contact.us@anthem.com ▪ **Website:** unicaremass.com If you call after business hours, you can leave a message. Member Services will return your call on the next business day.	**For questions about:** ▪ Benefits for a medical service or procedure ▪ Benefits for mental health or substance use disorder services ▪ Status of a medical or behavioral health claim ▪ Finding a doctor, hospital, or other healthcare provider ▪ These sections of this handbook: ▫ Part 1: Getting Started (pages 11-31) ▫ Part 2: Your Benefits and Coverage (pages 33-88) ▫ Part 3: Using Your Plan (pages 89-140)
Questions about prescription drug coverage	
Express Scripts ▪ **Customer Service:** 855-283-7679 (toll free) ▪ **Website:** www.express-scripts.com	**For questions about:** ▪ Benefits for a prescription drug ▪ Status of a prescription drug claim ▪ Where to get prescriptions filled ▪ Which drugs are covered ▪ This section of this handbook: ▫ Part 4: Your Prescription Drug Benefits (pages 141-155)
Questions about Employee Assistance Program (EAP) benefits	
Optum ▪ **Customer Service:** 844-263-1982 (toll free) ▪ **Website:** www.liveandworkwell.com *(Use access code: Mass4You)*	**For questions about your Employee Assistance Program (EAP) benefits**

If you have other questions, including questions about premiums or participation in any Group Insurance Commission (GIC) programs, please fill out the GIC's online contact form available at https://www.mass.gov/forms/contact-the-gic.

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GETTING STARTED

Introducing the PLUS plan

For questions about any of the information in Part 1 of this handbook, please call UniCare Member Services at 833-663-4176.

Administered by

UniCare

Chapter 1: First things first

Be sure to read this handbook carefully to learn about the benefits and features of your Plan. If you have questions, see the contact information on page 3.

About this plan

Introducing the PLUS plan

This handbook is a guide to benefits for you and your dependents covered under **UniCare State Indemnity Plan/PLUS** (**the PLUS plan**).

Your PLUS plan benefits are provided through the Group Insurance Commission (GIC), the state agency responsible for the design and payment of all benefits for state, participating municipalities and other governmental entities' employees and retirees. The Plan is funded by the Commonwealth of Massachusetts and administered by UniCare. UniCare provides most administrative services – including claims processing, member services, preapproval reviews and case management – at its service center in Andover, Massachusetts. UniCare is not the fiduciary or the insurer of UniCare State Indemnity Plan/PLUS.

The PLUS plan offers comprehensive coverage for many health services including hospital stays, surgery, emergency care, preventive care, outpatient services and other medically necessary treatment. Keep in mind, however, that benefits can differ depending on the service and the provider, and that not all services are covered by the Plan.

About PLUS providers

You get the highest benefits when you use **PLUS providers** for your care. PLUS providers are:

- ❑ All physicians, hospitals, and ambulatory surgery centers in Massachusetts
- ❑ UniCare preferred vendors
- ❑ Contracted providers who have agreed to accept UniCare's payment as payment in full:
  - Contracted behavioral health providers
  - Contracted specialized health facilities in Massachusetts (such as dialysis centers)
  - Contracted providers outside of Massachusetts
- ❑ LiveHealth Online telehealth providers

See "Types of health care providers" on pages 102-106 to find out more about these providers.

About this handbook

Benefits described in this handbook

This handbook looks at features and coverage for these types of benefits:	
Medical services	These benefits are administered by UniCare
Behavioral health services	These benefits, which cover mental health and substance use disorder services, are administered by UniCare in partnership with **Beacon Health Options**
Prescription drugs	These benefits are separately administered by **Express Scripts**

Where to find information in this handbook

A note about terms and definitions

Definitions for many of the terms used in this handbook appear in Chapter 11 (pages 131-140). You should also keep in mind that:

- ❑ The formal name of your plan is **UniCare State Indemnity Plan/PLUS**. In this handbook and other plan materials, we usually refer to it as the **PLUS plan**, **PLUS**, or **the Plan**.
- ❑ We often use the abbreviation **GIC** for the **Group Insurance Commission**.
- ❑ If you have dependents covered under your plan, text that refers to **you** also applies to your dependents.
- ❑ **Medical services (medical care)** are services to treat medical (physical) conditions. **Behavioral health services** are services to treat mental health and substance use disorder conditions. When we're talking about both types of services together, we usually call them **healthcare services**.

Symbols used in this handbook

Table 1. What the handbook symbols mean

What the handbook symbols mean	
	**Important information** – This may have an impact on your benefits or costs.
	**No coverage, limited coverage, or benefit restriction** – A full list of Plan exclusions and limitations appears in Chapter 7.
	**May need preapproval review** – This service may need to be reviewed to determine if it is eligible for benefits. See Chapter 3.
	**Use UniCare preferred vendors** – To get the best benefit, use a UniCare preferred vendor for this service or product. See pages 105-106 to learn more.
	**Use Sydney Health** – You can do this through the Sydney Health app (page 127).
	**Go to unicaremass.com** – This information can be found at our website.

Do you have other health insurance?

If you or a family member has health coverage from an insurer other than UniCare, you may need to fill out and send an *Other Health Insurance (OHI)* form to UniCare.

UniCare needs this information to coordinate your benefits with other plans. To learn more about how this works, turn to "Coordinating benefits with other health plans (COB)" on pages 121-124.

Find this and other forms at unicaremass.com.

You don't need to submit an OHI form if…

- ❑ You don't have coverage under any other health plans, or
- ❑ You do have other coverage, but it's from AARP, MassHealth or TRICARE, ***or***
- ❑ You've already submitted an OHI form and your coverage hasn't changed.

You do need to submit an OHI form if…

- ❑ You're covered under another health plan, and that plan is not AARP, MassHealth or TRICARE, ***and***
- ❑ You either haven't submitted an OHI form before or else the form you submitted previously needs to be updated.

About your ID cards

Every PLUS member will get either one or two UniCare ID cards, depending on where they live. These cards have useful information about your benefits, as well as important telephone numbers you and your healthcare providers may need.

About your ID cards	
If you live in Massachusetts	We'll send you a blue UniCare ID card to use whenever and wherever you get health care.
If you live outside of Massachusetts	We'll send you two ID cards: ▪ Use the **green network card** when you get services from contracted providers in the state where you live (your **home state**). ▪ Use the **blue UniCare ID card** when you travel.
Your prescription drug card is separate	Express Scripts will send your prescription drug cards separately. Call Express Scripts at 855-283-7679 if you have questions about your prescription drug card.

If you'd prefer to use an electronic ID card instead of a physical card, you can access yours through the Sydney Health app.

You can order replacement physical cards from unicaremass.com.

Some services need preapproval

In this handbook, services marked with a **telephone** ☎ require preapproval (preauthorization) review to determine if the services are eligible for benefits. Your provider must notify UniCare if you're having a service that requires review. See Chapter 3 for information about how preapprovals work.

Getting the most out of PLUS

For a description of the different kinds of providers and facilities mentioned in Table 2, see “Types of health care providers” on pages 102-106.

Table 2. How to get the most out of PLUS

Always use PLUS providers		See pages
Your benefits are highest – and your member costs are lowest – when you use PLUS providers for your care	PLUS providers are: ▪ All physicians, hospitals, and ambulatory surgery centers in Massachusetts ▪ UniCare preferred vendors ▪ Contracted behavioral health providers ▪ Contracted specialized health facilities in Massachusetts ▪ Contracted providers outside of Massachusetts ▪ LiveHealth Online telehealth providers	102-106
When you use PLUS specialized health facilities	Contracted specialized health facilities are PLUS providers and are covered at 100%. Otherwise, these facilities are covered at 80%, so you’ll owe 20% coinsurance.	106
✓ **When you use preferred vendors**	Services and equipment from preferred vendors are covered at 100%. Non-preferred vendors are covered at 80%, so you’ll owe 20% coinsurance. In this handbook, the **checkmark** ✓ indicates a preferred vendor benefit.	105-106
Tips on choosing providers		**See pages**
Choose a PCP in an Enhanced Personal Health Care practice	You have a $15 copay when your PCP participates in UniCare’s **Enhanced Personal Health Care** program. For other PCPs, the copay is $20.	102
Use Tier 1 or Tier 2 medical specialists	Your copays are lower when you use medical specialists who are Tier 1 or Tier 2.	47, 107-108
For hospital care, use a Tier 1 or Tier 2 hospital	Your copays are lower at Tier 1 and Tier 2 hospitals in Massachusetts.	103-104, 163-164
Use PLUS behavioral health providers	PLUS behavioral health providers won’t balance bill you for charges over the Plan’s allowed amounts.	103
If you need care quickly, take advantage of walk-in clinics	You have a $20 copay at walk-in clinics like urgent care centers and retail health clinics. At a hospital emergency room, you’ll owe a $100 copay.	49-51, 105
Have outpatient surgery at an ambulatory surgery center	There’s no copay when you have surgery at an independent ambulatory surgery center (not run by a hospital). Outside of Massachusetts, be sure it’s a UniCare-contracted location.	72-73, 104

Getting care outside of Massachusetts		See pages
Use contracted (PLUS) providers outside of Massachusetts	If you live or travel outside of Massachusetts, be sure to use contracted providers when you need healthcare services. Contracted providers are PLUS providers who have agreed to accept UniCare's payment as payment in full – they won't balance bill you.	27, 106
Make sure your out-of-state dependents use contracted providers, too	Covered dependents who live outside of Massachusetts should also use contracted providers when they need healthcare services.	27, 106
Other ways to keep your costs down		**See pages**
Use LiveHealth Online telehealth services	From your computer or mobile device, you can consult with a doctor, therapist, or psychiatrist for a $15 copay.	105
Compare costs with the transparency tool	The transparency tool lets you compare costs for common procedures with Massachusetts providers.	129
Tips to help prevent billing surprises		**See pages**
Avoid outpatient facilities that are owned by hospitals	Sometimes, outpatient facilities – like urgent care centers and ambulatory surgery centers – are owned by hospitals, and may bill as hospitals. That can cost you more. If you're not sure, you may want to ask how your visit will be billed.	104
Learn the difference between preventive and diagnostic care	When you have a preventive visit with your doctor, you could be billed if you have any services that are diagnostic instead of preventive. Get to know what your preventive benefits are – see Chapter 6.	85-88

Chapter 2: About costs and billing

The ABCs of medical bills

When you get a medical bill, it's often hard to understand what needs to be paid, and who needs to pay what. Here are some basics about medical billing that are worth knowing, and that may help everything make a bit more sense:

Medical services are almost never just one service.

You already know that health care is complicated, but nothing makes that more obvious than when the bill arrives. Let's say you go to the doctor for a tetanus shot – one simple service, right? Then when the bill comes, you see separate charges for the office visit with the doctor, the administration of the shot (the injection itself), and the tetanus serum (what's in the injection).

This is how medical billing works, and this is why you'll often see more than one charge on a medical bill.

Not all services are paid for (covered) by insurance.

Your insurance covers most services that are **medically necessary** – services that you need in order to take care of your health. There are some services that aren't covered; you have to pay for those yourself. Cosmetic services are one example of services that are usually not medically necessary and that insurance doesn't cover. Also, most insurance plans have a list of services that are **excluded** (never covered). You can find the list of services that are excluded or limited in Chapter 7.

Even when a service is covered, it doesn't mean that insurance will pay whatever the doctor charged.

Insurance covers up to the **allowed amount** for a service, which may not be the amount that's on the bill. An allowed amount is the most that your insurance will pay.

Let's say the allowed amount for the tetanus serum in your shot is $80. Even if the doctor charged $100 for the serum, insurance will pay no more than $80 – the allowed amount. Remember: 100% coverage means 100% of the allowed amount, *not* 100% of the bill.

Some providers take the allowed amount as their full payment, and some don't.

Providers who have contracted with your health plan accept the allowed amount as complete payment. Non-contracted providers don't. Non-contracted providers can bill you for the difference between what they billed and what your health plan paid. This is called **balance billing**. See page 27 for information about balance billing protection in Massachusetts.

> **What is a provider?** A healthcare **provider** is a person, place, or organization that delivers healthcare services or supplies. A provider can be a **person** (like a doctor), a **place** (like a hospital), or an **organization** (like hospice).

So, who pays what?

Your insurer pays the allowed amounts for your tetanus shot. You may also owe a fee, called a copay, at the doctor's office. When you pay something toward the healthcare services you get, that's known as **cost sharing**. The costs that you must pay yourself are your **member costs**.

The next several pages talk about the different member costs you pay toward your health care: **deductibles**, **copays** and **coinsurance**.

What member costs are (out-of-pocket costs)

Member costs are the costs that you pay toward your medical bills. Member costs are also called **out-of-pocket costs** or **cost sharing**.

There are three kinds of member costs. These costs are separate and unrelated; they apply in different situations and to different services.

Types of member costs		See pages
Deductible	A set dollar amount you owe toward services each year before the Plan starts paying benefits for those services.	19-21
Copays	A fixed amount you pay when you get certain healthcare services, like seeing your doctor for a sprained ankle.	21-25
Coinsurance	For some services, the Plan pays 80% and you pay the other 20%. The 20% that you owe is called coinsurance.	25

There are limits on how much you could pay for these costs. **Out-of-pocket maximums** cap how much you'll spend each plan year on the combination of deductible, copays and coinsurance. See pages 25-26 to learn about your out-of-pocket maximums.

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

How member costs work

If you owe any member costs, we'll send you an *Explanation of Benefits* (EOB), which is a statement that shows how the claim has been paid and what member costs you owe.

When UniCare gets a claim for services that you or someone in your family had, we subtract any member costs you owe from the amount we pay to that provider. The copay, if there is one, gets subtracted first. Then the deductible – if it applies – is subtracted, and finally the coinsurance, if any.

After getting payment from UniCare, your provider will bill you for any member costs – copays, deductible and/or coinsurance – that UniCare subtracted from its payment. (If you had any services from that provider that weren't covered by your Plan, the provider's bill may include those charges too.)

UniCare processes claims as they come in. This means that your claims may not get paid in the same order in which you got the services.

About your deductible

A **deductible** is a set dollar amount you pay toward certain services each plan year before the Plan starts paying benefits for those services. Your deductibles start at the beginning of each plan year (in other words, on July 1, when your plan coverage starts each year).

The deductible applies to some – but not all – covered services. For example, you owe your deductible for inpatient care, but not for occupational therapy. Inpatient care is *subject to the deductible*, but occupational therapy is not.

Depending on how much a claim is for, it may take more than one claim before you have *satisfied* (fully paid) your deductible. Once you have paid all of this year's deductible, you won't owe any more toward that deductible until the next plan year starts.

Under the PLUS plan, you have three deductibles:

- ❑ The **PLUS deductible** applies to services from PLUS providers
- ❑ The **non-PLUS deductible** applies to services from non-PLUS providers
- ❑ A separate **prescription drug deductible** is described in Part 4 of this handbook

Table 3. How much are my deductibles?

	What is my deductible when I use PLUS providers?	What is my deductible when I use non-PLUS providers?
For an individual (each plan year)	**$500 for one person**	**$500 for one person**
For a family (each plan year)	**$1,000 for the entire family** *For any one person in the family, the deductible is capped at $500*	**$1,000 for the entire family** *For any one person in the family, the deductible is capped at $500*

What's the difference between the PLUS and non-PLUS deductibles?

Your PLUS deductible applies when you get services from PLUS providers. Your non-PLUS deductible applies to medical claims from non-PLUS providers.

Table 4. How the PLUS and non-PLUS deductibles compare

PLUS deductible applies to claims from:	Non-PLUS deductible applies to claims from:
▪ All physicians, hospitals, and ambulatory surgery centers in Massachusetts ▪ UniCare preferred vendors ▪ Contracted behavioral health providers ▪ Contracted specialized health facilities in Massachusetts ▪ Contracted providers outside of Massachusetts	▪ Non-contracted behavioral health providers ▪ Non-contracted specialized health facilities in Massachusetts ▪ Non-preferred vendors ▪ Non-contracted providers outside Massachusetts

How an individual deductible works

An **individual deductible** is the amount that one person must pay before the Plan starts to pay for any services the deductible applies to. (The following example is for the PLUS deductible, but the non-PLUS deductible works the same way.)

> **Example** – In July, you get services from a PLUS provider and pay $200 toward that deductible. You now have $300 of that deductible that you haven't paid yet. In August, you get more services from a PLUS provider. If this second bill is *more* than $300, you pay the $300 deductible you still owe, and the Plan pays the covered amount of the rest of the bill. But if the August bill is *less* than $300, you'll owe the rest of your PLUS deductible next time you have services that the PLUS deductible applies to.

How a family deductible works

If you have dependents who are covered under your plan, then you also have **family deductibles**. A family deductible is the maximum amount that you and your family could pay in a plan year. The most you'll owe for any one family member is $500, until the family as a whole reaches the $1,000 family limit. (The following example is for the PLUS deductible, but the non-PLUS deductible works the same way.)

> **Example** – In July, you and your two children get services from PLUS providers and each of you pay $300 deductibles. This means you've paid $900 of your family PLUS deductible. In August, your spouse gets services from a PLUS provider and pays $100 deductible – the rest of your family PLUS deductible. Even though no one person has reached the $500 cap, you've paid the entire $1,000 family PLUS deductible. You won't have to pay any more deductible for anyone in your family for the rest of the plan year.

About copays

What's a copay?

A **copay** is a payment you owe at the time you get a service. For example, you pay a copay when you go to your doctor for a sore throat, or when you have outpatient surgery at a hospital.

Not all services require a copay. You have copays for some medical services and for some behavioral health services.

How do copays work?

Copays can work in two ways:

- ❑ **Per-visit copays** – You pay per-visit copays every time you have that service. Doctor visits, high-tech imaging, physical therapy, occupational therapy, and emergency room visits all have per-visit copays.
- ❑ **Quarterly copays** – You pay quarterly copays only once each calendar quarter, no matter how many times you get that service during the quarter. Inpatient care has 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.

Which services have copays?

Table 5 lists all of the Plan's copays, arranged by what type of service the copays are for:

- ❑ **When you go to the doctor** – Copays for visits to a provider at a doctor's office, clinic, or through telehealth.
- ❑ **For other medical services (not at a hospital)** – Copays for medical services that don't take place at a hospital (or in a hospital-owned facility).
- ❑ **For medical services at a hospital** – Copays for inpatient and outpatient medical services you get at a hospital.
- ❑ **For behavioral health services** – Copays for services to treat mental health and substance use disorder conditions.

Table 5. Which services have copays?

	Copay with PLUS providers	Copay with non-PLUS providers
Copays when you go to a doctor – Visits may be in person or through telehealth ***Important:*** *See the telehealth notice on page 47.*		
Primary care (PCP) visit ▪ With an Enhanced Personal Health Care PCP (page 102)	$15	*Not applicable*
▪ All other PCP visits	$20	$20
Specialist visit in Massachusetts	▪ Tier 1: $30 ▪ Tier 2: $60 ▪ Tier 3: $75	*Not applicable*
Specialist visit outside Massachusetts	$60	$60
LiveHealth Online telehealth visit	$15	*Not applicable*
Urgent care center visit	$20	$20
Retail clinic visit	$20	$20
Copays for other medical services (not at a hospital)		
Routine eye exam ▪ With an optometrist	$60	$60
▪ With an ophthalmologist	Specialist copay	Specialist copay
Physical therapy	$20	$20
Occupational therapy	$20	$20
Chiropractic care	$20	$20
High-tech imaging *(MRIs, CT scans and PET scans)*	$100 per day	$100 per day
Copays for medical services at a hospital		
Inpatient medical care ▪ At a hospital in Massachusetts	▪ Tier 1: $275 per quarter ▪ Tier 2: $500 per quarter ▪ Tier 3: $1,500 per quarter	$500 per quarter
▪ At a hospital outside Massachusetts	$500 per quarter	$500 per quarter
▪ At a rehab facility	$500 per quarter	$500 per quarter
▪ Under the following two circumstances: ▫ Transplant at a Quality Center or Designated Hospital for transplants (page 74) ▫ Neonatal ICU at a designated hospital (page 62)	$275 per quarter	$275 per quarter
Hospital emergency room (ER) visit	$100 per visit	$100 per visit

	Copay with PLUS providers	Copay with non-PLUS providers
Outpatient surgery at a Massachusetts hospital	▪ Tier 1: $110 per quarter ▪ Tier 2: $110 per quarter ▪ Tier 3: $250 per quarter	$110 per quarter
Outpatient surgery at a non-Massachusetts hospital	$110 per quarter	$110 per quarter
Outpatient high-tech imaging at a hospital *(MRIs, CT scans and PET scans)*	$100 per day	$100 per day
Copays for behavioral health services – Visits may be in person or through telehealth		
Inpatient behavioral health care	$200 per quarter	$200 per quarter
Medication management	$15	$20
Office services	$15	$20
Telehealth – See the notice on page 83. *When using LiveHealth Online or a PLUS provider, you don't owe a copay for the first three visits.*	▪ LiveHealth Online: $15 ▪ Other PLUS providers: Copay of the service being provided	Copay of the service being provided
Therapy (outpatient)	$15	$20

Doctor visit copays

You owe a copay when you have a visit with a doctor. Doctor visit copays apply when you see a doctor at a medical practice, a clinic, or through telehealth. The amount of the copay depends on whether you're seeing a primary care provider (PCP) or a specialist, as shown in Table 5.

- ❑ A **PCP (primary care provider)** can be a nurse practitioner, physician assistant or physician whose specialty is family medicine, general medicine, pediatrics, geriatrics or internal medicine.
- ❑ A **specialist (specialty care provider)** can be a nurse practitioner, physician assistant or physician. Copays for specialists depend on the specialist's tier assignment. For more information about specialist tiering, see pages 107-108.

Important! Some specialists may also provide primary care. If so, they are considered specialists when we determine their tier assignments. This means you will pay the specialist copay even if you go to that specialist for primary care.

Copays for inpatient care

You owe an inpatient quarterly copay when you are admitted to a hospital for inpatient medical or behavioral health care. The total copay amount you owe depends on when and what type of inpatient services you get, and also on the hospital's tier assignment. Appendix B lists the tiers of all Massachusetts hospitals.

For inpatient medical services

You owe an inpatient copay just once during a calendar quarter. You won't owe any additional inpatient copay if you're readmitted within the same calendar quarter or within 30 days (as long as it's in the same plan year). (Note that there are two special cases when you'll owe the lowest copay when you use a designated hospital.)

For inpatient medical care	Copay (PLUS)	Copay (non-PLUS)
▪ The first time you're admitted	▪ Tier 1: $275 ▪ Tier 2: $500 ▪ Tier 3: $1,500	$500
▪ Admitted again during the same calendar quarter	$0	$0
▪ Admitted again within 30 days – in the same plan year	$0	$0
▪ Admitted again within 30 days – in a new plan year	▪ Tier 1: $275 ▪ Tier 2: $500 ▪ Tier 3: $1,500	$500
▪ If you're admitted under either of these circumstances: ▫ For a transplant at a Quality Center or Designated Hospital ▫ For neonatal ICU at a designated hospital	$275	$275

For behavioral health inpatient services

You owe an inpatient copay just once during a calendar quarter. You won't owe any additional inpatient copay if you're readmitted within the same calendar quarter or within 30 days (as long as it's in the same plan year).

For behavioral health inpatient care	Copay (PLUS)	Copay (non-PLUS)
▪ The first time you're admitted	$200	$200
▪ Admitted again during the same calendar quarter	$0	$0
▪ Admitted again within 30 days – in the same plan year	$0	$0
▪ Admitted again within 30 days – in a new plan year	$200	$200

If you owe different inpatient copays in the same calendar quarter

If you get inpatient services during one calendar quarter at hospitals that have different inpatient copays, you owe the amount of the higher copay.

This means that if the copay for the first hospital is higher, you won't owe any copay at the second. But if the copay for the first hospital is lower, you'll owe the balance when you go to the second hospital.

Example – You have inpatient behavioral health services, so you owe a $200 copay. Then, during the same quarter, you have inpatient services at a Tier 2 hospital where the copay is $500. You will owe $300 because you already paid $200 toward your inpatient copay for this quarter.

The copay at a hospital emergency room (ER)

You owe the ER copay each time you go to an emergency room at a hospital. If you get admitted to the hospital from the ER, this copay is waived and the inpatient copay will apply instead.

The copay for outpatient surgery at a hospital

You owe a quarterly copay when you have outpatient surgery at a hospital, or at a location that is owned by a hospital.

You won't owe this copay if you have your surgery at a non-hospital-owned location, such as an ambulatory surgery center.

What is a non-hospital-owned location? **Non-hospital-owned locations** are facilities that perform outpatient medical services but that are not owned or operated by a hospital. Non-hospital-owned locations include many ambulatory surgery centers, urgent care centers and doctor's offices.

Copays for behavioral health office and therapy services

You owe a copay each time you get behavioral health office services or therapy.

- ❑ Behavioral health office services are described on pages 81-82.
- ❑ Behavioral health outpatient therapy is described on page 84.

For these services, you'll owe a lower copay when you use a PLUS behavioral health provider. You'll have a higher copay if you use a non-PLUS provider, and you also risk being balance billed by non-PLUS providers. See page 103 for information about behavioral health providers.

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%.

Limits on your out-of-pocket costs

There are limits on many of the out-of-pocket costs you'll have to pay each year toward covered services. Once you reach a cost limit, the Plan pays 100% of the allowed amounts for the services that the limit applies to.

Under the PLUS plan, you have two different cost limits: the **PLUS out-of-pocket (OOP) maximum** and the **non-PLUS out-of-pocket (OOP) maximum**.

The PLUS out-of-pocket (OOP) maximum

The **PLUS OOP maximum** limits the member costs you owe for services from PLUS providers (both medical and behavioral health) and for prescription drugs.

Table 6. How much is the PLUS OOP maximum?

How much is the PLUS OOP maximum?	
For an individual	**$5,000 for one person (each plan year)**
For a family	**$10,000 for the entire family (each plan year)** *For any one person in the family, this maximum is $5,000*

The following costs count toward reaching the PLUS OOP maximum:

- ❑ PLUS deductible and prescription drug deductible
- ❑ Copays and coinsurance for services with PLUS providers
- ❑ Copays for prescription drugs
- ❑ Copays and coinsurance for emergency services from any provider

The following costs ***do not*** count toward toward reaching the PLUS OOP maximum:

- ❑ Member costs for any services from non-PLUS providers
- ❑ Premiums
- ❑ Balance bills (charges over the Plan's allowed amounts) – See "About balance billing" on the next page for information about balance billing protection in Massachusetts
- ❑ Costs for health care that the Plan doesn't cover

The non-PLUS out-of-pocket (OOP) maximum

The **non-PLUS OOP maximum** limits the member costs you owe for services from non-PLUS providers (both medical and behavioral health).

Table 7. How much is the non-PLUS OOP maximum?

How much is the non-PLUS OOP maximum?	
For an individual	**$5,000 for one person (each plan year)**
For a family	**$10,000 for the entire family (each plan year)** *For any one person in the family, this maximum is $5,000*

The following costs count toward reaching the non-PLUS OOP maximum:

- ❑ Non-PLUS deductible
- ❑ Copays and coinsurance for services with non-PLUS providers

The following costs ***do not*** count toward toward reaching the non-PLUS OOP maximum:

- ❑ Member costs for any services from PLUS providers
- ❑ Premiums
- ❑ Balance bills (charges over the Plan's allowed amounts)
- ❑ Costs for health care that the Plan doesn't cover

About allowed amounts

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

About balance billing

The allowed amount for a given service may not be the same as what a provider actually billed for that service. When a provider asks you to pay for charges over the allowed amount (that is, above the amount paid by insurance), it is called **balance billing**. The Plan doesn't cover balance bills for care you get outside of Massachusetts, as discussed below. Also, balance bills do not count toward your out-of-pocket maximums.

When you get care in Massachusetts

- ❑ **Medical providers** – Medical providers in Massachusetts are not allowed to balance bill you for charges over the allowed amount (Massachusetts General Law, Chapter 32A: Section 20). If a Massachusetts medical provider balance bills you, contact UniCare Member Services at 833-663-4176 for help.
- ❑ **Behavioral health providers** – PLUS behavioral health providers won't balance bill you. However, non-PLUS behavioral health providers in Massachusetts may do so. If you have a continuing relationship with a non-PLUS behavioral health provider, you may make other payment arrangements with that provider in addition to the payments made by UniCare.

If you get care outside of Massachusetts

Outside of Massachusetts, you won't be balance billed as long as you use PLUS medical and behavioral health providers. PLUS providers have agreed to accept the Plan's payment as payment in full.

Non-PLUS medical and behavioral health providers may balance bill you for the difference between the Plan's allowed amounts and the provider's charges. Since the Plan doesn't cover balance bills, payment is your responsibility.

What to do if you get a balance bill

If you get a balance bill from any of the following providers, contact UniCare Member Services at 833-663-4176 for help. These are PLUS providers who aren't allowed to balance bill UniCare members.

- ❑ All physicians, hospitals, and ambulatory surgery centers in Massachusetts
- ❑ UniCare preferred vendors
- ❑ Contracted behavioral health providers both in and outside of Massachusetts
- ❑ Contracted specialized health facilities in Massachusetts (such as dialysis centers)
- ❑ Contracted providers outside of Massachusetts

However, balance bills from other providers are your responsibility to pay. Since the Plan doesn't cover balance bills, and since they don't count toward your out-of-pocket maximums, balance bills can end up being very costly.

Chapter 3: Getting preapproval

What is preapproval?

Preapproval (also called **preauthorization**) confirms that a service you're having will be eligible for benefits. By getting a service preapproved, you can make sure that the service is covered under the Plan.

In most cases, your doctor will provide UniCare with the information necessary to get services preapproved and you won't need to do anything. But, occasionally, you may need to work with your doctor to arrange for preapproval. For example, if you use a non-contracted provider outside Massachusetts, you may need to ask that doctor to contact UniCare about preapproval.

If someone (you or your provider) doesn't get preapproval when it's required, your benefits may be reduced or not paid at all. If you need help with a preapproval, UniCare Member Services can contact your provider to make the arrangements.

What else should I know?

Here are a few other points about the preapproval process that may be helpful to know:

- ❑ Submitting a claim for a service does not meet the requirement for preapproval. Your provider must contact UniCare for preapproval before the service takes place.
- ❑ You don't need to get preapproval if you are outside the continental United States (the continental U.S. includes all states except Alaska and Hawaii).
- ❑ In this handbook, the telephone ☎ marks services that need to be preapproved.
- ❑ If you're not sure whether a service needs preapproval, ask your doctor to check the list or contact UniCare to find out.

Who handles preapproval reviews?

Depending on the service, preapproval reviews are handled by **UniCare**, **AIM Specialty Health®**, or **IngenioRx**. AIM and IngenioRx are UniCare-affiliated companies that provide support for the preapproval process. Your provider will need to contact the appropriate reviewer for the service needing preapproval.

Reviewer / contact info
UniCare – Behavioral health services and some medical services ▪ 800-442-9300 TTY: 711 (toll free)
AIM Specialty Health – Some medical services; diagnostic imaging; rehab services; some other procedures ▪ 866-766-0247 (toll free) ▪ www.providerportal.com
IngenioRx – Specialty drugs ▪ 833-293-0659 (toll free) ▪ www.covermymeds.com/main/prior-authorization-forms/

Preapprovals for medical services

Table 8 lists types of medical services that need to be preapproved. This is a representative list only and is subject to change. If you need help determining if a service needs preapproval, contact UniCare Member Services at 833-663-4176.

Table 8. Types of medical services needing preapproval

Types of medical services needing preapproval	
Cardiology services ▪ Arterial duplex ▪ Diagnostic cardiac catheterization ▪ Diagnostic coronary angiography ▪ Percutaneous coronary intervention (PCI) ▪ Physiologic study arterial ▪ Resting transthoracic echocardiography ▪ Stress echocardiography ▪ Transesophageal echocardiography **Cleft palate and cleft lip services** **Colonography (virtual colonoscopy)** **Durable medical equipment (DME)** ▪ For equipment costing more than $1,000 ▪ Doesn't apply to oxygen and oxygen equipment **Enteral therapy** **Gender affirmation (reassignment) surgery** **Genetic testing** **High-tech imaging** ▪ CT/CTA scan ▪ MRI/MRA scan ▪ Nuclear cardiology ▪ PET scans ▪ SPECT scans **Home health care** **Hyperbaric oxygen therapy** **Inpatient hospital admissions**	**Musculoskeletal services** ▪ Interventional pain management ▪ Joint surgery ▪ Spine surgery **Oncology services** ▪ Chemotherapy ▪ Supportive drugs **Private duty nursing** **Radiation therapy** ▪ Brachytherapy ▪ CyberKnife ▪ IMRT ▪ Proton beam ▪ Traditional radiation **Rehabilitation services** ▪ Occupational therapy ▪ Physical therapy ▪ Speech therapy **Skilled nursing facility admissions** **Sleep services** ▪ BPAP and CPAP equipment ▪ Sleep studies **Surgeries (selected)** **Transplants** ▪ Doesn't apply to cornea transplants **Varicose vein treatment** ▪ Includes sclerotherapy
Specialty drugs ▪ Prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis and multiple sclerosis. Specialty drugs are often high-cost and require special handling (like refrigeration during shipping) and administration (such as injection or infusion). ▪ A site of service review may be included in the preapproval review process. ▪ For a list of non-oncology specialty drugs that need preapproval through the prescription drug plan, see Part 4 of this handbook.	

Preapprovals for behavioral health services

To request preapproval for a behavioral health service 24 hours a day, seven days a week, your provider should contact UniCare.

Table 9 lists types of behavioral health services that need preapproval. For behavioral health services, the preapproval requirements may depend on whether you're getting services from a PLUS or non-PLUS behavioral health provider (see page 103 for information about behavioral health providers).

What is a DPH-licensed provider? The Massachusetts Department of Public Health (DPH) issues licenses to Massachusetts facilities that provide healthcare services. To be licensed, facilities must meet specific quality and safety standards.

Table 9. Types of behavioral health services needing preapproval

Behavioral health service	With PLUS providers	With non-PLUS providers
Inpatient services for mental health treatment		
▪ Acute residential treatment ▪ Community-based acute treatment (CBAT) ▪ Inpatient psychiatric services ▪ Transitional care units (TCU)	Needs preapproval	Needs preapproval
▪ Crisis stabilization units (CSU)	Needs preapproval for stays over 5 days	Needs preapproval for stays over 5 days
Inpatient services for substance use disorders (adults and adolescents)		
▪ Acute residential withdrawal management (ASAM level 3.7 detox) ▪ Clinical stabilization services (CSS) (ASAM level 3.5) ▪ Dual diagnosis acute treatment (DDAT) (ASAM level 3.5) ▪ Inpatient substance use disorder services, medically managed (ASAM level 4 detox)	▪ **In Massachusetts:** Notify UniCare within 48 hours ▪ **Outside Massachusetts:** Needs preapproval	▪ **DPH-licensed providers in Massachusetts:** Notify UniCare within 48 hours ▪ **All other non-contracted providers:** Needs preapproval
▪ Crisis stabilization units (CSU)	Needs preapproval for stays over 5 days	Needs preapproval for stays over 5 days
Office services		
▪ Acupuncture withdrawal management	N/A	Needs preapproval
▪ Applied Behavior Analysis (ABA) ▪ Dialectical behavioral therapy (DBT) ▪ Psychiatric visiting nurse services ▪ Transcranial magnetic stimulation (TMS)	Needs preapproval	Needs preapproval

Behavioral health service	With PLUS providers	With non-PLUS providers
Outpatient services		
▪ Day treatment	N/A	Needs preapproval
▪ Community support programs (CSP) ▪ Family stabilization teams (FST) ▪ Partial hospitalization programs for mental health conditions (PHP)	Needs preapproval	Needs preapproval
▪ Partial hospitalization programs for substance use disorders (PHP) (ASAM level 2.5)	▪ **In Massachusetts:** Notify UniCare within 48 hours ▪ **Outside Massachusetts:** Needs preapproval	▪ **DPH-licensed providers in Massachusetts:** Notify UniCare within 48 hours ▪ **All other non-contracted providers:** Needs preapproval
▪ Intensive outpatient programs (IOP) ▪ Structured outpatient addictions programs (SOAP)	Notify UniCare within 48 hours	▪ **DPH-licensed providers in Massachusetts:** Notify UniCare within 48 hours ▪ **All other non-contracted providers:** Needs preapproval

PART 2:

YOUR BENEFITS AND COVERAGE

Description of coverage for medical and behavioral health services

For questions about any of the information in Part 2 of this handbook, please call UniCare Member Services at 833-663-4176.

Administered by

UniCare

Chapter 4: Covered medical services

Summary of covered medical services

Table 10. Summary of costs for medical services

Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 27).

Service	Member costs with PLUS providers	Member costs with non-PLUS providers	See page
Ambulances	PLUS deductible	PLUS deductible	39
Bereavement counseling	PLUS deductible and 20% coinsurance (limited to $1,500 for a family in a plan year)	Non-PLUS deductible and 20% coinsurance (limited to $1,500 for a family in a plan year)	58
Cardiac rehab programs	PLUS deductible	Non-PLUS deductible and 20% coinsurance	40
Chemotherapy	PLUS deductible	Non-PLUS deductible and 20% coinsurance	41
Chiropractic care	$20 copay and 20% coinsurance (limited to 20 visits in a plan year)	$20 copay, non-PLUS deductible, and 20% coinsurance (limited to 20 visits in a plan year)	41
✓ **Diabetic supplies**	PLUS deductible	Non-PLUS deductible and 20% coinsurance	45
Dialysis	PLUS deductible	Non-PLUS deductible and 20% coinsurance	46
Doctor visits – in-person or through telehealth	*See the telehealth notice on page 47.*		47
▪ Enhanced Personal Health Care PCP visits	$15 copay	*Not applicable*	
▪ Other PCP visits	$20 copay	$20 copay, non-PLUS deductible, and 20% coinsurance	
▪ Specialist visits	$30/60/75 copay	$60 copay, non-PLUS deductible, and 20% coinsurance	
▪ LiveHealth Online	$15 copay	*Not applicable*	

Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 27).

Service	Member costs with PLUS providers	Member costs with non-PLUS providers	See page
Doctors – other services			47
▪ At an emergency room	PLUS deductible	PLUS deductible	
▪ For inpatient hospital care	PLUS deductible	Non-PLUS deductible and 20% coinsurance	
▪ For outpatient hospital care	$30/60/75 copay	$60 copay, non-PLUS deductible, and 20% coinsurance	
Drug screening (lab tests)	PLUS deductible	Non-PLUS deductible and 20% coinsurance	48
☎✓ **Durable medical equipment (DME)**	PLUS deductible	Non-PLUS deductible and 20% coinsurance	48
Early intervention programs	No member costs	No member costs	49
Emergency room visits	$100 copay and PLUS deductible	$100 copay and PLUS deductible	49
Eye exams (routine)	$30/60/75 copay (limited to one exam every 24 months)	$60 copay and 20% coinsurance (limited to one exam every 24 months)	51
Eyeglasses and contact lenses	PLUS deductible and 20% coinsurance (limited to the first lenses within six months of eye injury or cataract surgery)	PLUS deductible and 20% coinsurance (limited to the first lenses within six months of eye injury or cataract surgery)	52
Family planning services	No member costs	No member costs	53
Fitness reimbursement	Reimbursed up to $100 for the family in a plan year	Reimbursed up to $100 for the family in a plan year	53
Hearing aids			55
▪ Age 21 and under	No member costs (limited to $2,000 for each impaired ear every 24 months)	No member costs (limited to $2,000 for each impaired ear every 24 months)	
▪ Age 22 and over	No member costs for first $500, then 20% coinsurance of the next $1,500 (up to a total benefit limit of $1,700 every 24 months)	No member costs for first $500, then 20% coinsurance of the next $1,500 (up to a total benefit limit of $1,700 every 24 months)	
Hearing exams	$15/20/30/60/75 copay	$20/60 copay, non-PLUS deductible, and 20% coinsurance	55

Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 27).

Service	Member costs with PLUS providers	Member costs with non-PLUS providers	See page
☎ **High-tech imaging (e.g., MRIs, CT scans)**			56
▪ Emergency room	PLUS deductible	PLUS deductible	
▪ Inpatient hospital	PLUS deductible	Non-PLUS deductible and 20% coinsurance	
▪ Outpatient hospital and non-hospital-owned locations	$100 daily copay and PLUS deductible	$100 daily copay, non-PLUS deductible, and 20% coinsurance	
☎ ✓ **Home health care**	PLUS deductible	Non-PLUS deductible and 20% coinsurance	56
✓ **Home infusion therapy**	PLUS deductible	Non-PLUS deductible and 20% coinsurance	57
Hospice care	PLUS deductible	Non-PLUS deductible and 20% coinsurance	57
Immunizations (vaccines)	No member costs (you may have costs for the office visit)	No member costs (you may have costs for the office visit)	59
☎ **Inpatient medical care**			60
▪ At a hospital or rehab facility (semi-private room)	$275/500/1,500 quarterly copay and PLUS deductible ($500 copay outside of MA)	$500 quarterly copay, non-PLUS deductible, and 20% coinsurance	
▪ At a hospital or rehab facility (medically necessary private room)	▪ **First 90 days:** $275/500/1,500 quarterly copay and PLUS deductible ($500 copay outside of MA) ▪ **After 90 days:** Dollar difference between the semi-private room rate and the private room rate	▪ **First 90 days:** $500 quarterly copay, non-PLUS deductible, and 20% coinsurance ▪ **After 90 days:** 20% coinsurance, and the dollar difference between the semi-private room rate and the private room rate	
▪ Neonatal ICU	▪ **At a designated hospital:** $275 quarterly copay and PLUS deductible ▪ **At other hospitals:** $275/500/1,500 quarterly copay and PLUS deductible ($500 copay outside of MA)	▪ **At a designated hospital:** $275 quarterly copay and PLUS deductible ▪ **At other hospitals:** $500 quarterly copay, non-PLUS deductible, and 20% coinsurance	
Lab services			62
▪ Emergency room	PLUS deductible	PLUS deductible	
▪ Hospital inpatient, outpatient, and non-hospital-owned locations	PLUS deductible	Non-PLUS deductible and 20% coinsurance	

Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 27).

Service	Member costs with PLUS providers	Member costs with non-PLUS providers	See page
Medical services, if not listed elsewhere	PLUS deductible and 20% coinsurance	Non-PLUS deductible and 20% coinsurance	64
☎ **Occupational therapy**	$20 copay	$20 copay and non-PLUS deductible	64
Outpatient hospital services, if not listed elsewhere	PLUS deductible	Non-PLUS deductible and 20% coinsurance	65
✓ **Oxygen**	PLUS deductible	Non-PLUS deductible and 20% coinsurance	65
Personal Emergency Response Systems (PERS)			66
▪ Installation	PLUS deductible and 20% coinsurance (limited to $50 in a plan year)	PLUS deductible and 20% coinsurance (limited to $50 in a plan year)	
▪ Rental	PLUS deductible and 20% coinsurance (limited to $40 a month)	PLUS deductible and 20% coinsurance (limited to $40 a month)	
☎ **Physical therapy**	$20 copay	$20 copay and non-PLUS deductible	66
Prescription drugs	Benefits are administered by Express Scripts and are described in Part 4 (pages 141-155). Call Express Scripts at 855-283-7679 for more information.		141
Preventive care *See Table 17 on page 85.*	No member costs	No member costs	67
☎ **Private duty nursing in a home setting**	PLUS deductible and 20% coinsurance (limited to $8,000 in a plan year)	Non-PLUS deductible and 20% coinsurance (limited to $8,000 in a plan year)	68
Prosthetics and orthotics			68
▪ Breast prosthetics	PLUS deductible	Non-PLUS deductible	
▪ Other prosthetics and orthotics	PLUS deductible and 20% coinsurance	Non-PLUS deductible and 20% coinsurance	
☎ **Radiation therapy**	PLUS deductible	Non-PLUS deductible and 20% coinsurance	70

Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 27).

Service	Member costs with PLUS providers	Member costs with non-PLUS providers	See page
Radiology (e.g., X-rays, ultrasounds)			70
▪ Emergency room	PLUS deductible	PLUS deductible	
▪ Inpatient hospital	PLUS deductible	Non-PLUS deductible and 20% coinsurance	
▪ Outpatient hospital and non-hospital-owned locations	PLUS deductible	Non-PLUS deductible and 20% coinsurance	
Retail health clinic visits	$20 copay	$20 copay	49
☎ **Skilled nursing and long-term care facilities**	PLUS deductible and 20% coinsurance (limited to 45 days in a plan year)	PLUS deductible and 20% coinsurance (limited to 45 days in a plan year)	60
☎ **Speech therapy**			71
▪ With an autism diagnosis	No member costs	Non-PLUS deductible and 20% coinsurance	
▪ All other speech therapy	No member costs (limited to 20 visits in a plan year)	Non-PLUS deductible and 20% coinsurance (limited to 20 visits in a plan year)	
☎ **Surgery**			72
▪ Inpatient hospital	PLUS deductible (you also have an inpatient copay)	Non-PLUS deductible and 20% coinsurance (you also have an inpatient copay)	
▪ Outpatient hospital	$110/110/250 quarterly copay and PLUS deductible ($110 copay outside of MA)	$110 quarterly copay, non-PLUS deductible, and 20% coinsurance	
▪ Non-hospital-owned locations	PLUS deductible	Non-PLUS deductible and 20% coinsurance	
Telehealth	*See "Doctor visits" on page 34 and the telehealth notice on page 47.*		
Tobacco cessation counseling	No member costs (limited to 300 minutes in a plan year)	No member costs (limited to 300 minutes in a plan year)	73
☎ **Transplants**			74
▪ At a Quality Center or Designated Hospital for transplants	$275/500/1,500 quarterly copay and PLUS deductible	$275/500/1,500 quarterly copay and PLUS deductible	
▪ At other hospitals	$275/500/1,500 quarterly copay, PLUS deductible, and 20% coinsurance	$500 quarterly copay, non-PLUS deductible, and 20% coinsurance	
Urgent care center visits	$20 copay	$20 copay	49

Allergy shots

Allergy shots are covered. Claims for allergy shots may separately itemize the shot itself, the allergy serum (in the shot), and the office visit (when the shots were given).

	With PLUS providers	With non-PLUS providers
Shot (injection)	PLUS deductible	Non-PLUS deductible
Allergy serum	PLUS deductible and 20% coinsurance	Non-PLUS deductible and 20% coinsurance
Office visit	▪ **With a PCP:** $15/20 copay ▪ **With a specialist:** $30/60/75 copay	▪ **With a PCP:** $20 copay, non-PLUS deductible, and 20% coinsurance ▪ **With a specialist:** $60 copay, non-PLUS deductible, and 20% coinsurance

Ambulances

Ambulance transportation is covered in a medical emergency. Stroke, heart attack, difficulty breathing, and severe pain are all examples of medical emergencies. Covered transportation may be by ground, air or sea ambulance.

	With PLUS providers	With non-PLUS providers
Ambulance transportation	PLUS deductible	PLUS deductible

Restrictions:

- The ambulance services must be medically necessary and take you to the nearest hospital that can treat your emergency condition.
- Inter-facility transfers by ground ambulance are only covered if you are in a facility that cannot treat your condition or when needed to support discharge planning to a lower level of care; in both cases, the transfer is limited to the nearest facility that can provide treatment.
- Inter-facility transfers by air or sea ambulance must be medically necessary and are only covered if you are in a facility that cannot treat your condition; the transfer is limited to the nearest facility that can provide emergency treatment.
- Transfers to a hospital that you prefer (e.g., to be closer to home) are not covered.
- Transportation to scheduled appointments (such as dialysis treatment) is not covered because it is not considered an emergency.
- Transportation in chair cars or vans is not covered.
- There is no coverage for charges for ambulance calls that are then refused.

Anesthesia

Anesthesia and its administration are covered when given for a covered procedure. Anesthesia for electroconvulsive therapy (ECT) is also covered.

	With PLUS providers	With non-PLUS providers
Anesthesia and its administration	PLUS deductible	Non-PLUS deductible and 20% coinsurance

Restrictions:

- Other charges associated with ECT are covered under your behavioral health benefit (Chapter 5).
- 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, preapproval reviews, benefit limitations, and provider payment methods. Medical services needed for diagnosis and treatment (such as occupational therapy) are covered as a medical benefit. Behavioral health services are covered as a behavioral health benefit (pages 77-78).

Cardiac rehabilitation (rehab) programs

Cardiac rehab programs are professionally-supervised, multi-disciplinary programs to help people recover from cardiac events like heart attacks, heart surgery, and coronary procedures such as stenting and angioplasty. Covered cardiac rehab includes education and counseling services to help increase physical fitness, reduce cardiac symptoms, improve health, and reduce the risk of future heart problems.

	With PLUS providers	With non-PLUS providers
Cardiac rehab programs	PLUS deductible	Non-PLUS deductible and 20% coinsurance

A cardiac rehab program must:

- ❑ Be ordered by a physician
- ❑ Be operated by a licensed clinic or hospital
- ❑ Teach and monitor risk reduction, lifestyle adjustments, therapeutic exercise, proper diet, use of proper prescription drugs, self-assessment, and self-help skills
- ❑ Meet the generally accepted standards of cardiac rehab

This benefit covers the *active* rehabilitation phase of the program, which is usually three consecutive months.

Restrictions:

- You must start the program within six months after your cardiac event.
- You can participate in only one cardiac rehab program after a cardiac event.
- Cardiac rehab programs are limited to 36 visits (three visits per week for 12 weeks).
- There is no coverage for the *maintenance* phase of a cardiac rehab program. Coverage is for the *active* phase only.
- You are not covered for a cardiac rehab program if you have not had a cardiac event.

Chemotherapy

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

	With PLUS providers	With non-PLUS providers
Outpatient	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Inpatient	Covered under the benefit for hospital admissions (page 60)	

Chiropractic care

The Plan covers up to 20 chiropractic visits each plan year, when they are used on a short-term basis to treat neuromuscular and/or musculoskeletal conditions and when the potential for functional gain exists.

	With PLUS providers	With non-PLUS providers
Chiropractic care	$20 copay and 20% coinsurance (limited to 20 visits in a plan year)	$20 copay, non-PLUS deductible, and 20% coinsurance (limited to 20 visits in a plan year)

Restrictions:

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

Circumcision

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

	With PLUS providers	With non-PLUS providers
Circumcision	PLUS deductible	Non-PLUS deductible and 20% coinsurance

Cleft lip and cleft palate

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, preapproval reviews, and provider payment methods.

Benefits include:

- ❑ Audiology
- ❑ Medical
- ❑ Nutrition services
- ❑ Oral and facial surgery
- ❑ Speech therapy
- ❑ Surgical management and follow-up care by oral and plastic surgeons

The following benefits are available if they are not otherwise covered by a dental plan:

- ❑ Dental services
- ❑ Orthodontic treatment and management
- ❑ Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy

Restrictions:

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

These services need preapproval.

Clinical trials (clinical research studies)

The Plan covers patient care services provided as part of a qualified clinical trial studying potential treatments for cancer. Patient care services include items and services provided when you are enrolled in a qualified clinical trial consistent with your diagnosis and the study protocol. Coverage is subject to all pertinent provisions of the Plan including medical necessity review, use of participating providers, preapproval reviews, and provider payment methods.

The Plan covers patient care services provided within the trial only if it is a **qualified clinical trial** according to state law:

- ❑ The clinical trial is to study potential treatments for cancer.
- ❑ 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
- ❑ 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.

- ❑ With respect to Phase I clinical trials, the facility must be an academic medical center (or an affiliated facility) at which the clinicians conducting the trial have staff privileges.
- ❑ The member meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.
- ❑ The member has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.
- ❑ 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.
- ❑ The clinical trial does not unjustifiably duplicate existing studies.
- ❑ The clinical trial must have a therapeutic intent and must, to some extent, assume the effect of the intervention on the member.

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

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

Restrictions:

- There is no coverage for any clinical research trial other than a qualified clinical trial studying potential treatments for cancer.
- Patient care services do not include any of the following:
  - An investigational drug or device, except as noted above
  - Non-healthcare 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 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 UniCare State Indemnity Plan is a medical plan, not a dental plan, the Plan does not provide benefits for dental care. However, medical services that include treatment related to dental care are sometimes eligible for benefits. The Plan will only consider charges for dental care in the situations listed below.

- ❑ **Emergency treatment** from a dentist within 72 hours of an accidental injury to the mouth and sound natural teeth. Treatment must take place in an acute care setting (not a dentist's office) and is limited to trauma care, the reduction of pain and swelling, and any otherwise covered non-dental surgery and/or diagnostic X-rays.
- ❑ **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.
- ❑ **If you have a serious medical condition** (such as hemophilia or heart disease) that makes it necessary to have your dental care performed safely in a hospital, surgical day care unit, or ambulatory surgery center, only the following procedures are covered:
  - 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
- ❑ **Cleft lip or palate** (page 42) – The following services are covered specifically for the treatment of cleft lip or palate, if not otherwise covered by a dental plan:
  - Dental services
  - Orthodontic treatment
  - Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic or prosthetic treatment

Restrictions:

- There is no coverage for any services provided in a dentist's office.
- Facility fees, anesthesia and other charges related to non-covered dental services are not covered.
- Dentures, dental prosthetics and related surgery are not covered.
- Braces and other orthodontic treatment, including treatment done to prepare for surgery, are not covered.
- Treatment of temporomandibular joint (TMJ) disorder is limited to the initial diagnostic examination, initial testing and medically necessary surgery.

Diabetes care

Coverage for diabetes care applies to services prescribed by a doctor for insulin-dependent, insulin-using, gestational and non-insulin-dependent 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 (Chapter 6).

Diabetes prevention program reimbursement

You can get reimbursed for up to $500 when you complete at least 20 sessions of an approved diabetes prevention program. The Plan will reimburse you when you send us proof that you have completed a diabetes prevention program approved by the Massachusetts Department of Public Health or offered through the YMCA in other states.

	With PLUS providers	With non-PLUS providers
Diabetes prevention program reimbursement	Costs are reimbursed up to $500 per member (one time only)	Costs are reimbursed up to $500 per member (one time only)

To be eligible for this reimbursement, you must complete a diabetes prevention program listed on the **www.mass.gov** website. For a list of programs in Massachusetts, go to:

www.mass.gov/service-details/dpp-programs-in-massachusetts

Outside of Massachusetts, look for a program at a nearby YMCA:

www.ymca.net/diabetes-prevention/locate-participating-y

Use the *Diabetes Prevention Program Reimbursement* form to submit your request for this reimbursement.

Download this form from unicaremass.com. A copy of the form also appears in Appendix C.

Restrictions:

- Reimbursement is available only once per member.
- You must complete at least 20 sessions of the program.

Diabetic supplies

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

	With preferred vendors	With non-preferred vendors
✓ **Diabetic supplies**	PLUS deductible	Non-PLUS deductible and 20% coinsurance

The following supplies are covered under your 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
- ❑ Syringes and all injection aids
- ❑ Test strips for glucose monitors
- ❑ Therapeutic shoes for the prevention of complications associated with diabetes
- ❑ Urine test strips

Diabetes drugs (such as insulin and prescribed oral agents) are covered under your prescription drug plan. In addition, if you buy diabetic supplies at a pharmacy, the supplies may also be covered under your prescription drug plan. See Part 4 of this handbook (pages 141-155).

✕ Restrictions:

- Coverage for therapeutic shoes is limited to one pair each year.
- Special shoes purchased to accommodate orthotics, or to wear after foot surgery, are not covered.

☎ Preapproval is required for equipment costing more than $1,000.

✓ **Use preferred vendors** (page 105) – Supplies from UniCare preferred vendors are covered at 100% of the allowed amount. Supplies from non-preferred vendors are covered at 80%, so you owe 20% coinsurance. Your deductible applies to both types of vendors.

Find a list of UniCare preferred vendors at unicaremass.com.

Important! Non-preferred vendors are covered at 80%, even if you're 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 PLUS providers	With non-PLUS providers
Dialysis	PLUS deductible	Non-PLUS deductible and 20% coinsurance

✕ Restrictions:

- There is no coverage for transportation to dialysis appointments.
- There is no coverage for hemodialysis to treat a behavioral health condition.

Doctor and other medical provider services

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

Provider visits – In-person or telehealth (see notice below)	With PLUS providers	With non-PLUS providers
Primary care visits with an Enhanced Personal Health Care PCP (see page 102)	$15 copay	*Not applicable*
Other PCP visits	$20 copay	$20 copay, non-PLUS deductible, and 20% coinsurance
Specialist visits	$30/60/75 copay	$60 copay, non-PLUS deductible, and 20% coinsurance
LiveHealth Online	$15 copay	*Not applicable*
Other provider services	**With PLUS providers**	**With non-PLUS providers**
Emergency room care	PLUS deductible	PLUS deductible
Inpatient hospital care	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Outpatient hospital care	$30/60/75 copay	$60 copay, non-PLUS deductible, and 20% coinsurance

Telehealth notice – Regulations concerning future telehealth benefits are currently under review in Massachusetts. For updates on telehealth services, requirements, and benefits, check unicaremass.com.

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:

- There is no coverage for physicians to be available in case their services are needed (for example, a stand-by physician in an operating room). The Plan only pays providers for the actual delivery of medically necessary services.

Drug screening (lab tests)

Lab tests for drug screening, such as blood and urine tests, are covered when ordered by a doctor.

	With PLUS providers	With non-PLUS providers
Lab tests for drug screening	PLUS deductible	Non-PLUS deductible and 20% coinsurance

✕ Restrictions:

- Drug screening tests must be performed by a medical provider, such as a hospital or medical laboratory.
- There is no coverage for drug screening that is:
  - Required solely for the purposes of career, education, housing (e.g., sober living facilities), sports, camp, travel, employment, insurance, marriage, or adoption
  - Ordered by a court, except as required by law
  - Required to obtain or maintain a license of any type

Durable medical equipment (DME)

Durable medical equipment (DME) is equipment and supplies – such as wheelchairs, crutches, oxygen and respiratory equipment – that is ordered by a doctor for daily or extended use. The Plan covers medically necessary DME if the item meets all of the following requirements:

- ❑ Designed primarily for therapeutic purposes or to improve physical function
- ❑ Able to withstand repeated use
- ❑ Provided in connection with the treatment of disease, injury or pregnancy
- ❑ Ordered by a physician
- ❑ Provided by a DME supplier

	With preferred vendors	With non-preferred vendors
☎ ✓ **Breast pumps**	No member costs	20% coinsurance
☎ ✓ **Other DME**	PLUS deductible	Non-PLUS deductible and 20% coinsurance

The Plan covers rental or purchase depending on the item, its use, and the expected total cost.

✕ Restrictions:

- Coverage is limited to medically necessary equipment that meets the requirements listed above. Types of equipment that are not covered under the DME benefit include:
  - Equipment intended for athletic or recreational use (e.g., exercise equipment, wheelchairs for sports)
  - Items intended for environmental control or home modification (e.g., electronic door openers, air cleaners, dehumidifiers, elevators, ramps, stairway lifts)
  - Added, non-standard features or accessories (e.g., hand controls for driving, transit systems that secure wheelchairs in moving vehicles, wheelchair customizations)
  - Items specifically designed to be used outdoors (e.g., special wheelchairs for beach access, equipment for use on rough terrain)

- Items that serve as backup by duplicating other equipment (e.g., a manual wheelchair as backup for a powered wheelchair)
- Equipment upgrades or replacements for items that function properly or that can be repaired

- There is no coverage for personal items that could be purchased without a prescription (e.g., air conditioners, arch supports, bed pans, blood pressure cuffs, commodes, computer-assisted communications devices, corrective shoes, heating pads, hot water bottles, incontinence supplies, lift or riser chairs, molding helmets, non-hospital beds, orthopedic mattresses, shower chairs, telephones, televisions, thermal therapy devices, whirlpools).
- Compression stockings are covered up to a limit of four pairs within a 365-day period.
- The Plan will not cover any rental charges that exceed the purchase price of an item.

☎ **BPAP and CPAP equipment need preapproval. Other DME needs preapproval if costing more than $1,000 (rental and/or purchase)** – This requirement doesn't apply to oxygen or oxygen equipment.

✓ **Use preferred vendors** (page 105) – DME and related supplies from UniCare preferred vendors are covered at 100% of the allowed amount. DME and related supplies from non-preferred vendors are covered at 80%, so you owe 20% coinsurance. Your deductible applies to both types of vendors.

Find a list of UniCare preferred vendors at unicaremass.com.

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

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 healthcare 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 PLUS providers	With non-PLUS providers
Early intervention programs	No member costs	No member costs

Emergency care / urgent care

If you are facing a medical or behavioral health emergency, go to the nearest emergency department or call 911 (or the local emergency medical services number). Keep emergency numbers and your doctors' phone numbers in a place that's easy to reach.

The Plan covers emergency room and urgent care services from various types of providers. Emergency room services have the same level of coverage whether you get them from PLUS or non-PLUS providers.

If you're admitted to a Massachusetts hospital from the emergency room, you'll owe the inpatient copay for that hospital's tier. If you're admitted to a non-PLUS hospital, you'll owe the non-PLUS inpatient copay.

Emergency / urgent care	With PLUS providers	With non-PLUS providers
Hospital emergency room	$100 copay and PLUS deductible (copay is waived if admitted to the hospital)	$100 copay and PLUS deductible (copay is waived if admitted to the hospital)
Urgent care center visits	$20 copay	$20 copay
Retail health clinic visits	$20 copay	$20 copay
Medical practice visits	▪ **With a PCP:** $15/20 copay ▪ **With a specialist:** $30/60/75 copay	▪ **With a PCP:** $20 copay, non-PLUS deductible, and 20% coinsurance ▪ **With a specialist:** $60 copay, non-PLUS deductible, and 20% coinsurance

An **emergency** is an illness or medical condition, whether physical or behavioral, characterized by symptoms of sufficient severity that the absence of prompt 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
- ❑ In the case of pregnancy, a threat to the safety of a member or her unborn child

Some examples of illnesses or medical conditions requiring emergency care are severe pain, a broken leg, loss of consciousness, vomiting blood, chest pain, difficulty breathing, or any medical condition that is quickly worsening.

Urgent care refers to services you get when your health is not in serious danger but you need medical attention right away. Some conditions you might seek urgent care for are listed in Table 11.

Table 11. Example conditions for urgent care

When you might want to get urgent care	
▪ Cough	▪ Minor allergic reactions
▪ Sore throat	▪ Bumps, cuts, and scrapes
▪ Minor fever, cold or flu	▪ Minor burn or rash
▪ Nausea, vomiting, or diarrhea	▪ Burning with urination
▪ Back pain	▪ Eye swelling, pain, redness or irritation
▪ Muscle strain or sprain	▪ Animal bites
▪ Ear or sinus pain	▪ Stitches
▪ Mild headache	▪ X-rays or lab tests

For urgent care, your member costs are lower if you go to a walk-in clinic instead of a hospital emergency department. Walk-in clinics are sites that offer medical care on a walk-in basis, so no appointment is needed. Although walk-in clinics have a variety of different names, they fall into four general categories. These four categories differ based on the services they offer and how they bill for their services.

- ❑ **Medical practices** – Some doctors' offices offer services to walk-in patients. They offer the services you'd expect to get at a primary care practice.
- ❑ **Retail health clinics** are located in retail stores or pharmacies. They offer basic services like vaccinations and treatment for colds or mild sinus infections.

- ❑ **Urgent care centers** are independent, freestanding locations that treat conditions that should be handled quickly but that aren't life-threatening. They often do X-rays, lab tests and stitches.
- ❑ **Hospitals** – Some hospitals have walk-in clinics within or associated with their emergency departments.

Important! A facility's name isn't always a guide to how it bills or what your member costs will be. For example, a walk-in clinic that calls itself an urgent care center may bill as a hospital emergency room or a medical practice, instead of as an urgent care center. Before you use a walk-in clinic, you may want to ask how your visit will be billed. As shown in the benefits chart (previous page), how your visit is billed determines how much you owe.

Restrictions:

- If you are admitted to a Massachusetts hospital from the emergency room, you'll owe the inpatient copay for that hospital's tier. If you're admitted to a non-PLUS hospital, you'll owe the non-PLUS inpatient copay.
- Charges for non-emergency services received at an emergency room are covered under the appropriate plan benefit. For example, a non-emergency CT scan would be covered under the high-tech imaging benefit (described on page 56) rather than the emergency room benefit.

Notify UniCare if you're admitted to the hospital from the emergency room.

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 preferred vendors	With non-preferred vendors
Enteral therapy	PLUS deductible	Non-PLUS deductible and 20% coinsurance

Enteral therapy needs preapproval.

Use preferred vendors (page 105) – 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%, so you owe 20% coinsurance. Your deductible applies to both types of vendors.

Find a list of UniCare preferred vendors at unicaremass.com.

Eye care

The Plan covers routine eye exams once every 24 months. Other eye care services are covered if you have eye problems due to a medical condition.

	With PLUS providers	With non-PLUS providers
Routine eye exams Refraction/glaucoma testing	$30/60/75 copay (limited to one exam every 24 months)	$60 copay and 20% coinsurance (limited to one exam every 24 months)
Eye care office visits When medically necessary	$30/60/75 copay	$60 copay, non-PLUS deductible, and 20% coinsurance

Routine eye exams can be performed by an ophthalmologist, optometrist or optician. They include the following parts:

- ❑ **Eye health** – This part of a routine eye exam checks the health of your eyes, such as testing for glaucoma, when you are not experiencing any eye issues or problems.
- ❑ **Vision (visual acuity)** – Eye exams that diagnose vision or treat vision problems are called *refraction*, or *refractive eye exams*. These exams measure how well you can see and whether you need your vision corrected. Visual acuity problems (*refractive errors*) include astigmatism, near-sightedness, far-sightedness, and aging-related blurry vision.

The Plan covers office visits (typically, with an ophthalmologist) for the monitoring and treatment of medical conditions that can harm the eyes. These include conditions such as diabetes, glaucoma, keratoconus, cataracts and macular degeneration.

Restrictions:

- Routine eye exams consist of checking eye health and visual acuity only. Other testing – such as visual fields, ophthalmoscopy or ophthalmic diagnostic imaging – is not considered routine and is not covered.
- There is no coverage for surgery or supplies to correct refractive errors (visual acuity problems). Non-covered services include orthoptics for vision correction, radial keratotomy, and other laser surgeries. Refractive errors include astigmatism, myopia (near-sightedness), hyperopia (far-sightedness), and presbyopia (aging-related blurry vision).
- Vision therapy is not covered.

Eyeglasses and contact lenses

Generally, the Plan does not cover eyeglasses or contact lenses. However, a set of eyeglasses or contact lenses is covered after an eye injury or cataract surgery. You must purchase the eyeglasses or contact lenses within six months of the surgery. Standard frames and lenses, including bifocal and trifocal lenses, are covered.

	With PLUS providers	With non-PLUS providers
Eyeglasses and contact lenses	PLUS deductible and 20% coinsurance (limited to first set within six months of eye injury or cataract surgery)	PLUS deductible and 20% coinsurance (limited to first set within six months of 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.

Family planning

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

	With PLUS providers	With non-PLUS providers
Family planning services	No member costs	No member costs

Covered services include:

- ❑ Fitting for a diaphragm or cervical cap
- ❑ Insertion, re-insertion, or removal of an IUD or Levonorgestrel (Norplant)
- ❑ Injection of progesterone (Depo-Provera)
- ❑ Office visits, including evaluations, consultations and follow-up care
- ❑ Voluntary female sterilization (tubal ligation)

FDA-approved contraceptive drugs and devices are available through your prescription drug plan (see Part 4 of this handbook).

Restrictions:

- There is no coverage for voluntary male sterilization (vasectomy) or voluntary termination of pregnancy (abortion) under the family planning benefit. These two procedures are covered as surgical procedures under your surgery benefit (pages 72-73).

Fitness reimbursement

You can get reimbursed for up to $100 per family on costs associated with participation in a fitness activity. This reimbursement is paid to the plan enrollee upon proof of payment.

	With PLUS providers	With non-PLUS providers
Fitness reimbursement	Costs are reimbursed up to $100 for a family each plan year	Costs are reimbursed up to $100 for a family each plan year

To receive the fitness reimbursement, you must attest to participating in physical activity an average of four or more times per month, and you must submit proof of payment toward an eligible activity. Eligible costs include:

- ❑ Gyms, health clubs, fitness centers, Boys & Girls Clubs of America, dance studios, martial arts centers, etc.
- ❑ Classes and programs such as yoga, Pilates, spin, Zumba, and gymnastics (either in-person or online)
- ❑ Organizations and leagues designed for fitness activities (e.g., sports teams, hiking, bowling, etc.)
- ❑ Personal trainers (either in-person or online)

Use the *Fitness Reimbursement* form to submit your request for this reimbursement.

Download this form from unicaremass.com. A copy of the form also appears in Appendix C.

Restrictions:

- Although any family member may have the fitness membership, the reimbursement is paid to the plan enrollee only.
- Ineligible costs include beach or country club memberships or dues; fees for one-day events; annual or day passes (such as for skiing); spas or spa services; personal or home fitness equipment.

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 PLUS providers	With non-PLUS providers
Routine foot care	▪ **With a PCP:** $15/20 copay ▪ **With a specialist:** $30/60/75 copay	▪ **With a PCP:** $20 copay, non-PLUS deductible, and 20% coinsurance ▪ **With a specialist:** $60 copay, non-PLUS deductible, and 20% coinsurance

Restrictions:

- Arch supports, such as Dr. Scholl's inserts, are not covered.

Gender affirmation (reassignment) services

Services for treatment associated with gender affirmation are covered like any other physical condition. Coverage is subject to all pertinent provisions of the Plan including medical necessity, use of participating providers, preapproval reviews, benefit limitations, and provider payment methods.

Medical services needed for diagnosis and treatment are covered under your medical benefit. Behavioral health services are covered as a behavioral health benefit (see Chapter 5).

Covered services include:

- ❑ Breast/chest ("top") and genital/reproductive organ ("bottom") surgeries
- ❑ Electrolysis (hair removal) when part of surgical preparation
- ❑ Facial reconstruction procedures, such as tracheal shaving
- ❑ Surgical repair and fertility preservation storage of up to 90 days

For a list of specific covered services, contact UniCare Member Services at 833-663-4176.

Restrictions:

- Fertility storage (storage of sperm or eggs) is limited to a maximum of 90 days.
- Surgical reversal of original procedure is not covered.

Gender reassignment services need preapproval.

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 office visits.

	With PLUS providers	With non-PLUS providers
Annual exam, with Pap smear	No member costs	No member costs
Office visits	▪ **With a PCP:** $15/20 copay ▪ **With a specialist:** $30/60/75 copay	▪ **With a PCP:** $20 copay, non-PLUS deductible, and 20% coinsurance ▪ **With a specialist:** $60 copay, non-PLUS deductible, and 20% coinsurance

Hearing aids

Hearing aids are covered to correct a member's hearing loss that has been documented through testing.

	With PLUS providers	With non-PLUS providers
Age 21 and under	No member costs (limited to $2,000 for each impaired ear every 24 months)	No member costs (limited to $2,000 for each impaired ear every 24 months)
Age 22 and over	No member costs for first $500, then 20% coinsurance of the next $1,500 (up to a total benefit limit of $1,700 every 24 months)	No member costs for first $500, then 20% coinsurance of the next $1,500 (up to a total benefit limit of $1,700 every 24 months)

Restrictions:

- Ear molds are not covered, except when needed for hearing aids for members age 21 and under.
- Hearing aid batteries are not covered.
- Replacement hearing aids are covered only if you have not reached the benefit limit, and if:
  - You need a new hearing aid prescription because your medical condition has changed, or
  - The hearing aid no longer works properly and cannot be repaired

Hearing exams

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

	With PLUS providers	With non-PLUS providers
Office visit	▪ **With a PCP:** $15/20 copay ▪ **With a specialist:** $30/60/75 copay	▪ **With a PCP:** $20 copay, non-PLUS deductible, and 20% coinsurance ▪ **With a specialist:** $60 copay, non-PLUS deductible, and 20% coinsurance
Testing	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Hearing screenings for newborns	No member costs	No member costs

Restrictions:

- Services provided in a school-based setting are not covered.
- The Plan does not cover services for developmental delays and disabilities that the law requires be provided by early intervention programs or schools. (Until age 3, children can get services under the benefit for early intervention programs. Then, Massachusetts Special Education Law (M.G.L. c. 71(b)) – known as Chapter 766 – requires Massachusetts school systems to provide services to address a child's disabilities. Similar laws apply in other states as well.)

High-tech imaging

High-tech imaging are tests such as MRIs, CT scans and PET scans that give a more comprehensive view of the human body than plain film X-rays. Many of these tests are also much more expensive than traditional X-rays.

	With PLUS providers	With non-PLUS providers
Emergency room	PLUS deductible	PLUS deductible
Inpatient hospital	PLUS deductible	Non-PLUS deductible and 20% coinsurance
☎ **Outpatient hospital and non-hospital-owned locations**	$100 daily copay and PLUS deductible	$100 daily copay, non-PLUS deductible, and 20% coinsurance

☎ **High-tech imaging needs preapproval.**

Home health care

Home health care includes any skilled services and supplies provided by a Medicare-certified home health care agency or **visiting nurse association (VNA)** on a part-time, intermittent, or visiting basis. Benefits for home health care are available when:

- ❑ Your doctor prescribes a **plan of care** – that is, a written order outlining services to be provided in the home – that will be administered by a home health care agency or VNA. The home health agency or VNA must meet any applicable licensing requirements.
- ❑ The services and supplies are provided in a non-institutional setting while you are housebound as a result of injury, disease or pregnancy.

The plan of care is subject to review and approval by the Plan.

	With preferred vendors	With non-preferred vendors
☎ ✓ **Home health care**	PLUS deductible	Non-PLUS deductible and 20% coinsurance

The following services are covered if they have been preapproved and if they are provided (or supervised) by a healthcare provider acting within the scope of his or her license:

- ❑ 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 appropriately licensed or certified therapist

- ❑ Durable medical equipment (DME) is covered under the DME benefit if the equipment is a medically necessary component of an approved plan of care

✕ Restrictions:

- There is no coverage for homemaking services or custodial care.
- There is no coverage for services received from someone who is in your immediate family. Your immediate family consists of you, your spouse and your children, as well as the brothers, sisters and parents of both you and your spouse. This includes any service that a provider may perform on himself or herself.
- There is no coverage for services received from anyone who shares your legal residence.

☎ Home health care needs preapproval.

✓ Use preferred vendors (page 105) – 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%, so you owe 20% coinsurance. Your deductible applies to both types of vendors.

Find a list of UniCare preferred vendors at unicaremass.com.

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 preferred vendors	With non-preferred vendors
✓ **Home infusion therapy**	PLUS deductible	Non-PLUS deductible and 20% coinsurance

✕ Restrictions:

- Non-oncology infused drugs require prior review and are dispensed by the prescription drug plan (see Part 4 of this handbook).
- You must get subcutaneous and intramuscular drugs through your prescription drug plan.

✓ Use preferred vendors (page 105) – 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%, so you owe 20% coinsurance. Your deductible applies to both types of vendors.

Find a list of UniCare preferred vendors at unicaremass.com.

Hospice and end-of-life care

Hospice provides multidisciplinary care to address the physical, social, emotional, and spiritual needs of persons likely to live a year or less. Hospice care has many benefits: better quality of life, better coping for you and your family, and longer survival time at home.

Hospice benefits are payable for covered services when a physician certifies (or re-certifies) that you have a medical prognosis of twelve months or less to live. The services must be furnished under a written plan of hospice care, established by a Medicare-certified hospice program, and periodically reviewed by the hospice's medical director and interdisciplinary team. Concurrent palliative chemotherapy and radiation therapy are permitted.

If you have a medical prognosis of greater than twelve months to live, but you have symptoms like severe pain or difficulty breathing, the Plan covers **palliative care** (page 65). Palliative care is focused on relieving pain or other symptoms of illness and improving the quality of life for patients and their families.

	With PLUS providers	With non-PLUS providers
Hospice care	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Bereavement counseling	PLUS deductible and 20% coinsurance (limited to $1,500 for the family in a plan year)	Non-PLUS deductible and 20% coinsurance (limited to $1,500 for the family in a plan year)

The Plan covers the following hospice services:

- ❑ Part-time, intermittent nursing care or home health aide services provided by or supervised by a registered nurse
- ❑ Physical, respiratory, occupational and speech therapy from an appropriately licensed or certified therapist
- ❑ Medical social services
- ❑ Medical supplies and medical appliances
- ❑ Drugs and medications prescribed by a physician and charged by the hospice
- ❑ Laboratory services
- ❑ Physician services
- ❑ Transportation to the place where you will be receiving covered hospice services
- ❑ Counseling provided by a physician, psychologist, clergy member, registered nurse, or social worker
- ❑ Dietary counseling from a registered dietitian
- ❑ Respite care in a hospital, a skilled nursing facility, a nursing home, or in the home. **Respite care** services are services given to a hospice patient to relieve the family or primary care person from caregiving functions.
- ❑ Bereavement counseling for family members (or for other persons specifically named by the person getting hospice care), within twelve months of death. Services must be provided by a physician, psychologist, clergy member, registered nurse, or social worker.

✕ Restrictions:

- Respite care is limited to a total of five days.
- Bereavement counseling is limited to $1,500 per family. Additional counseling services are available under your behavioral health benefits (Chapter 5).
- 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.

Immunizations (vaccines)

Immunizations (vaccines) recommended by the U.S. Preventive Services Task Force are covered at 100%, according to the preventive care schedule (Chapter 6).

	With PLUS providers	With non-PLUS providers
At a doctor's office	No member costs (but you may owe member costs for the office visit)	No member costs (but you may owe member costs for the office visit)
At a travel clinic	No member costs	No member costs
At a pharmacy	Covered under your prescription drug plan (pages 141-155)	Covered under your prescription drug plan (pages 141-155)

Restrictions:

- Unless you are pregnant, there is no coverage for blood tests (titers) to determine if you need an immunization. See **Immunization titers** on page 95.
- The shingles vaccine is only covered for members age 50 and over (as approved by the FDA).

Infertility treatment

Non-experimental infertility procedures are covered. 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:

- ❑ Within 12 months, if the woman is age 35 or under
- ❑ Within 6 months, if the woman is over 35

If a pregnancy ends in miscarriage, the time spent trying to conceive (prior to the pregnancy) is counted as part of the 12-month or six-month window.

The Plan provides benefits for the following procedures:

- ❑ In vitro fertilization and embryo placement (IVF-EP)
- ❑ Artificial insemination (AI), also known as intrauterine insemination (IUI)
- ❑ Cryopreservation of eggs as a component of covered infertility treatment.
- ❑ Gamete intrafallopian transfer (GIFT)
- ❑ Intracytoplasmic sperm injection (ICSI) for the treatment of male factor infertility
- ❑ Natural ovulation intravaginal fertilization (NORIF)
- ❑ Sperm, egg and/or inseminated egg procurement and processing, from yourself or from a donor, to the extent that these costs are not covered by a donor's insurer, if any
- ❑ Zygote intrafallopian transfer (ZIFT)

Other charges associated with covered infertility services – such as laboratory, physician and surgery costs – are covered under the appropriate plan benefit. For example, any medically necessary lab tests would be covered under the benefit for lab tests.

Restrictions:

- There is no coverage if the inability to conceive results from either voluntary sterilization or normal aging (menopause).
- In vitro fertilization is limited to five attempts per lifetime. (Other infertility procedures, such as artificial insemination, are not limited.) An **attempt** is defined as the start of a reproductive cycle with the intention of implanting a fertilized ovum. The occurrence of either of the following events constitutes an attempt:
  - Starting drug therapy to induce ovulation
  - Operative procedures to implant a fertilized ovum

  If the process is started and then cancelled (before the ovum is implanted), it is still counted as an attempt.
- Experimental infertility procedures are not covered.
- The Plan does not pay people to donate their eggs or sperm.
- 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 are covered only for the treatment of infertility.
- Infertility services provided as part of gender reassignment treatment (page 54) do not need to meet the definition of infertility described in this section.
- Storage fees for storing or banking sperm, eggs, and/or inseminated eggs are covered only when provided as part of gender reassignment treatment, and are limited to a maximum of 90 days in storage.
- The Plan does not pay people to be surrogates (gestational carriers) for UniCare plan members, and there is no coverage for medical services, including in vitro fertilization, for a surrogate who is not a UniCare member.
- Facility fees are only covered at a licensed hospital or ambulatory surgery center.
- There is no coverage for infertility procedures that don't meet the above definition of infertility.

Inpatient medical care (hospital admissions)

The Plan covers hospital services when you are admitted to an inpatient facility. Facilities that provide inpatient hospital care include acute care hospitals, rehabilitation facilities, long-term care facilities, and skilled nursing facilities. Coverage for inpatient hospital services includes all medically necessary services and supplies.

The benefit for hospital services depends on the type of facility you go to and the type of care you get:

- **Acute care hospitals** are medical centers and community hospitals that provide treatment for a severe illness, for conditions caused by disease or trauma, and for recovery from surgery. These hospitals deliver intensive, 24-hour medical and nursing care.
- **Rehabilitation (rehab) facilities** are specialized hospitals that provide rehab services to restore basic functioning (such as walking or sitting upright) that was lost due to illness or injury. Patients in these facilities have a good potential for recovery and are able to participate in a rehab program that includes therapy services for three to five hours a day.
- **Long-term care facilities** are specialized hospitals that treat patients who need further care for complex medical conditions but that no longer require the services of a traditional hospital. These patients' needs are mostly medical and their ability to participate in rehab is limited.

- ❑ **Skilled nursing facilities** provide lower intensity rehab and medical services. Patients in these facilities have continuing medical needs that require skilled nursing care, but do not need daily physician care. Some of these patients may or may not require rehab, while others may need long-term custodial care (see "Restrictions," later in this section).

At a hospital or rehab facility	With PLUS providers	With non-PLUS providers
☎ **Inpatient medical care (semi-private room)**	$275/500/1,500 quarterly copay and PLUS deductible ($500 copay outside of MA)	$500 quarterly copay, non-PLUS deductible, and 20% coinsurance
☎ **Inpatient medical care (medically necessary private room)**	▪ **First 90 days:** $275/500/1,500 quarterly copay and PLUS deductible ($500 copay outside of MA) ▪ **After 90 days:** Dollar difference between the semi-private room rate and the private room rate	▪ **First 90 days:** $500 quarterly copay, non-PLUS deductible, and 20% coinsurance ▪ **After 90 days:** 20% coinsurance and the dollar difference between the semi-private room rate and the private room rate
☎ **Neonatal ICUs (page 62)**	▪ **At a designated hospital:** $275 quarterly copay and PLUS deductible ▪ **At other hospitals:** $275/500/1,500 quarterly copay and PLUS deductible ($500 copay outside of MA)	▪ **At a designated hospital:** $275 quarterly copay and PLUS deductible ▪ **At other hospitals:** $500 quarterly copay, non-PLUS deductible, and 20% coinsurance
At a skilled nursing or long-term care facility	**With PLUS providers**	**With non-PLUS providers**
☎ **Inpatient medical care**	PLUS deductible and 20% coinsurance (limited to 45 days in a plan year)	PLUS deductible and 20% coinsurance (limited to 45 days in a plan year)

Table 12 lists examples of the services and supplies covered under the benefit for inpatient care.

Table 12. Examples of covered inpatient services

Examples of covered inpatient services and supplies	
▪ Room and board	▪ Pre-admission testing
▪ Intensive care/coronary care	▪ Ancillary items and services, such as:
▪ Physician and nursing services	▫ Infusions and transfusions
▪ Surgery	▫ Devices that are an integral part of a surgical procedure such as hip joints, skull plates and pacemakers
▪ Anesthesia, radiology and pathology	▫ Drugs, medications, solutions, biological preparations, and supplies
▪ Dialysis	▫ Use of special rooms, like operating rooms
▪ Physical, occupational and speech therapy	▫ Use of special equipment
▪ Diagnostic tests, radiology and labs	
▪ Durable medical equipment	
▪ Medically necessary services and supplies charged by the hospital	

Restrictions:

- The 45-day plan year limit is the total of all inpatient days at skilled nursing facilities and long-term care facilities, even if they took place at more than one facility and/or more than one admission.
- If a newborn is admitted to the hospital independently of the mother, it is considered a separate hospital admission and you will owe a separate inpatient copay.
- There is no coverage for custodial care. **Custodial care** is a level of care that is chiefly designed to assist with activities of daily living and cannot reasonably be expected to greatly restore health or bodily function.
- Private rooms are covered only if medically necessary.
- There is no coverage for private duty nursing in an inpatient facility.
- The Plan does not pay for donated blood.
- Convenience items such as telephone, radio and television are not covered.
- Services that are considered experimental or investigational 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.
- There is no coverage for charges for services that are not medically necessary.

Notify UniCare about any inpatient stay.

Neonatal ICUs

The Plan has identified certain hospitals with significant experience and patient volume for neonatal ICU care. Because significant clinical experience is likely to enhance the quality of care, the Plan covers neonatal ICUs at the following hospitals at the PLUS Tier 1 copay:

- ❑ Beth Israel Deaconess Medical Center
- ❑ Brigham and Women's Hospital
- ❑ UMass Memorial Medical Center

Laboratory services (lab work)

Diagnostic lab work is covered when prescribed by a physician.

	With PLUS providers	With non-PLUS providers
Emergency room	PLUS deductible	PLUS deductible
Hospital inpatient, outpatient, or non-hospital-owned location	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Preventive lab work *(see Chapter 6)*	No member costs when done according to the preventive care schedule	No member costs when done according to the preventive care schedule

Long-term care facilities

Long-term care facilities are specialized hospitals that treat patients who need further care for complex medical conditions but that no longer require the services of a traditional hospital. Services at long-term care facilities are covered under the benefit for inpatient care (pages 60-62).

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, preapproval reviews, and provider payment methods. Medical services needed for diagnosis and treatment are covered under your medical benefit.

Maternity care is often billed as a global (all-inclusive) service. When this is the case, you owe an office visit copay for the first visit but not for subsequent visits with the original doctor. However, services from other providers are not covered within the global service arrangement. Those services are billed separately and additional member costs (copays, deductible, and coinsurance) may apply.

Restrictions:

- If a newborn is admitted to the hospital independently of the mother, it is considered a separate hospital admission and you will owe a separate inpatient copay.

Medical care outside the U.S.

The Plan covers medically necessary services you get outside of the United States. Coverage is subject to all pertinent provisions of the Plan including benefit limitations and provider payment methods.

- **Emergency care** – The Plan covers emergency care anywhere in the world. Emergency services are covered at 100% of UniCare's allowed amounts after any deductible and copay amounts that apply.
- **Elective services** – Elective services outside the U.S. are covered according to the provisions and limitations described in this handbook. Benefits may differ depending on the service and the provider, and not all services are covered by the Plan.

  The amount UniCare pays non-U.S. providers is determined by the Plan's allowed amount for the service. If a provider's bill is more than the allowed amount (more than UniCare will pay), you may have to pay the additional charges yourself.

To receive payment for medical services outside the U.S., you or the provider must file a claim for each service. If we get a bill from the provider, we will pay the provider directly.

If you file the claim yourself, your claim must include written proof of the service and of your payment, as described on pages 108-109. If your bill has information in a foreign language, please provide a translation, if possible.

Charges for non-U.S. services are converted to U.S. dollars using the exchange rate found on www.oanda.com. The claim is paid based on these converted amounts.

Restrictions:

- Ambulance transportation is covered only in an emergency, and only for transportation to the nearest facility that can treat the condition.
- There is no coverage for ambulance transportation, including air ambulance, to a specified or preferred facility if a nearer facility can provide treatment.
- Repatriation expenses are not covered.

Medical services (if not listed elsewhere)

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 PLUS providers	With non-PLUS providers
Covered medical services (if not listed elsewhere)	PLUS deductible and 20% coinsurance	Non-PLUS deductible and 20% coinsurance

Neuropsychological (neuropsych) testing

Neuropsych testing is covered whether ordered for a medical condition or a behavioral health condition. See pages 81-82 for coverage details.

Occupational therapy

The Plan covers occupational therapy on a short-term basis when the potential for functional gain exists. One-on-one therapies are covered only when ordered by a physician and administered by a licensed occupational therapist or occupational therapy assistant (under the direction of an 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 PLUS providers	With non-PLUS providers
☎ **Occupational therapy**	$20 copay	$20 copay and non-PLUS deductible

✕ Restrictions:

- There is no coverage for:
  - Group occupational therapy
  - Sensory integration therapy
  - Occupational therapy to treat a chronic condition when that treatment is neither curative nor restorative
- Services provided in a school-based setting are not covered.
- The Plan does not cover services for developmental delays and disabilities that the law requires be provided by early intervention programs or schools. (Until age 3, children can get services under the benefit for early intervention programs. Then, Massachusetts Special Education Law (M.G.L. c. 71(b)) – known as Chapter 766 – requires Massachusetts school systems to provide services to address a child's disabilities. Similar laws apply in other states as well.)

☎ Occupational therapy needs preapproval.

Office visits

Office visits with primary care and specialty care providers are covered. See “Doctor and other medical provider services” on page 47 for coverage information.

Outpatient hospital services (if not listed elsewhere)

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 provided by a hospital that 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 PLUS providers	With non-PLUS providers
Outpatient hospital services (if not listed elsewhere)	PLUS deductible	Non-PLUS deductible and 20% coinsurance

Oxygen

Oxygen and its administration are covered.

	With preferred vendors	With non-preferred vendors
✓ **Oxygen**	PLUS deductible	Non-PLUS deductible and 20% coinsurance

Restrictions:

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

Use preferred vendors (page 105) – Supplies from UniCare preferred vendors are covered at 100% of the allowed amount. From non-preferred vendors, supplies are covered at 80%, so you owe 20% coinsurance. Your deductible applies to both types of vendors.

Find a list of UniCare preferred vendors at unicaremass.com.

Important! Non-preferred vendors are covered at 80%, even if you’re 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, preapproval reviews, and provider payment methods.

Personal Emergency Response Systems (PERS)

Installation and rental of a personal emergency response system (PERS) are covered when a doctor's letter attesting to its medical necessity is included with the claim.

	With PLUS providers	With non-PLUS providers
Installation	PLUS deductible and 20% coinsurance (limited to $50 in a plan year)	PLUS deductible and 20% coinsurance (limited to $50 in a plan year)
Rental	PLUS deductible and 20% coinsurance (limited to $40 a month)	PLUS deductible and 20% coinsurance (limited to $40 a month)

Restrictions:

- There is no coverage for the purchase of a PERS unit.

Physical therapy

The Plan covers physical therapy on a short-term basis when the potential for functional gain exists. One-on-one therapies are covered only when ordered by a physician and administered by a licensed physical therapist or physical therapy assistant (under the direction of a physical therapist).

Physical therapy is hands-on treatment to relieve pain, restore function and/or minimize disability resulting from disease or injury to the neuromuscular and/or musculoskeletal system, or the loss of a body part. Physical therapy may include direct manipulation, exercise, movement, and/or other physical modalities.

	With PLUS providers	With non-PLUS providers
☎ **Physical therapy**	$20 copay	$20 copay and non-PLUS deductible

Physical therapy must be:

- ❑ Ordered by a physician
- ❑ For the treatment of an injury or disease
- ❑ The most appropriate level of service needed to provide safe and adequate care
- ❑ Appropriate for the symptoms, consistent with the diagnosis, and consistent with generally accepted medical practice and professionally recognized standards

Restrictions:

- There is no coverage for:
  - Group physical therapy
  - Services provided by athletic trainers
  - Massage therapy and services provided by a massage therapist or neuromuscular therapist
  - Physical therapy to treat a chronic condition when that treatment is neither curative nor restorative
- Certain therapy services are not covered. These include, but are not limited to: acupuncture, aerobic exercise, craniosacral therapy, diathermy, infrared therapy, kinetic therapy, microwave therapy, paraffin treatment, Rolfing therapy, Shiatsu, sports conditioning, ultraviolet therapy, and weight training.
- Services provided by a chiropractor are considered chiropractic care, not physical therapy.
- Services provided in a school-based setting are not covered.

- The Plan does not cover services for developmental delays and disabilities that the law requires be provided by early intervention programs or schools. . (Until age 3, children can get services under the benefit for early intervention programs. Then, Massachusetts Special Education Law (M.G.L. c. 71(b)) – known as Chapter 766 – requires Massachusetts school systems to provide services to address a child's disabilities. Similar laws apply in other states as well.)

☎ **Physical therapy needs preapproval.**

Prescription drugs

Benefits for most prescription drugs are administered by Express Scripts. See Part 4 of this handbook (pages 141-155) for benefits information.

☎ **Certain specialty drugs need preapproval** – Specialty drugs are prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis and multiple sclerosis. Specialty drugs are often high-cost and require special handling (like refrigeration during shipping) and administration (such as injection or infusion). Some specialty drugs are covered by UniCare and require preapproval.

Other specialty drugs are covered under your prescription drug plan. See Part 4 of this handbook for a list of (non-oncology) specialty drugs that require preapproval through your prescription drug plan.

Preventive care

The Plan covers preventive or routine office visits, physical exams and other related preventive services that are recommended by the U.S. Preventive Services Task Force as part of the Affordable Care Act.

Covered preventive services are covered at 100% of the allowed amount, without any member costs. Preventive exams are covered according to the schedule issued by Massachusetts Health Quality Partners.

The schedule and guidelines for covered preventive services appears in Chapter 6.

	With PLUS providers	With non-PLUS providers
Preventive care	No member costs	No member costs

✕ **Restrictions:**

- Not all preventive healthcare services are recommended for everyone. You and your doctor should decide what care is appropriate for you.
- Claims must be submitted with the appropriate preventive diagnosis and procedure codes in order to be paid at 100%.
- If you are treated for an existing illness, injury or condition during your preventive exam, you may have to pay member costs for those non-preventive services.
- EKG (electrocardiogram) done solely for the purpose of screening or prevention is not covered.

Private duty nursing

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

	With PLUS providers	With non-PLUS providers
☎ **Private duty nursing in a home setting**	PLUS deductible and 20% coinsurance (limited to $8,000 in a plan year)	Non-PLUS deductible and 20% coinsurance (limited to $8,000 in a plan year)

Private duty nursing services must:

- ❑ Be medically necessary and ordered by a physician
- ❑ Provide skilled nursing services by a registered nurse for the treatment of an injury or disease
- ❑ Be exclusive of all other home health care services
- ❑ Not duplicate services that a hospital or facility is licensed to provide

Up to $4,000 (of the $8,000 plan-year limit) may be used for licensed practical nurse (LPN) services if a registered nurse is not available.

Restrictions:

- Outpatient private duty nursing is provided only when you are housebound.
- Private duty nursing services in a hospital or any other inpatient facility are not covered.
- There is no coverage for homemaking services or custodial care.
- There is no coverage for services received from someone who is in your immediate family. Your immediate family consists of you, your spouse and your children, as well as the brothers, sisters and parents of both you and your spouse. This includes any service that a provider may perform on himself or herself.
- There is no coverage for services received from anyone who shares your legal residence.

☎ Private duty nursing needs preapproval.

Prosthetics and orthotics

Prosthetics and orthotics, 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 devices used to restrict, align or correct deformities and/or to improve the function of moveable parts of the body. They are often attached to clothing and/or shoes, may assist in movement, and are sometimes jointed. Orthotics include braces, splints and trusses.

	With PLUS providers	With non-PLUS providers
Breast prosthetics	PLUS deductible	Non-PLUS deductible
Orthopedic shoe with attached brace	PLUS deductible	Non-PLUS deductible
Other prosthetics and orthotics (including mastectomy bras)	PLUS deductible and 20% coinsurance	Non-PLUS deductible and 20% coinsurance

Restrictions:

- Orthotics must be:
  - Ordered by a physician
  - Custom molded and fitted to your body
  - Used only by you
- 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.
- Mastectomy bras are limited to two bras every two years, unless a change to your prosthetic requires a replacement bra. Supporting documentation is required.
- The following items and services are not covered:
  - Arch supports (for example, Dr. Scholl's inserts)
  - Temporary or trial orthotics
  - Video tape gait analysis and diagnostic scanning
  - Orthopedic shoes that do not attach directly to a brace

Pulmonary rehabilitation (rehab) programs

Pulmonary rehab programs use a combination of education and exercise to help improve respiratory function in people diagnosed with breathing problems.

	With PLUS providers	With non-PLUS providers
Pulmonary rehab programs	PLUS deductible	Non-PLUS deductible and 20% coinsurance

A pulmonary rehab program must:

- ❑ Be ordered by a physician
- ❑ Be operated by a licensed clinic or hospital
- ❑ Meet the generally accepted standards of pulmonary rehab

This benefit covers the active rehabilitation phase of the program, which is usually three consecutive months.

Restrictions:

- To qualify for a pulmonary rehab program, you must have a diagnosed breathing problem such as chronic obstructive pulmonary disease (COPD) or pulmonary fibrosis.
- Pulmonary rehab programs are limited to 36 visits (three visits per week for 12 weeks).
- There is no coverage for the *maintenance* phase of a pulmonary rehab program. Coverage is for the *active* phase only.

Radiation therapy

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

	With PLUS providers	With non-PLUS providers
☎ **Radiation therapy**	PLUS deductible	Non-PLUS deductible and 20% coinsurance

☎ **Radiation therapy needs preapproval.**

Radiology (diagnostic imaging)

Radiology, also called diagnostic imaging, is a covered service. General radiology services covered under this benefit include X-rays and ultrasounds. Benefits for high-tech (advanced) imaging are shown on page 56.

	With PLUS providers	With non-PLUS providers
Emergency room	PLUS deductible	PLUS deductible
Inpatient hospital	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Outpatient hospital or non-hospital-owned location	PLUS deductible	Non-PLUS deductible and 20% coinsurance

Rehabilitation (rehab) hospitals

Rehabilitation (rehab) facilities are specialized hospitals that provide rehab services to restore basic functioning (such as walking or sitting upright) that was lost due to illness or injury. Services at rehab hospitals are covered under the benefit for inpatient care (pages 60-62).

Retail health clinics

Retail health clinics are clinics located in retail stores or pharmacies that offer basic medical services on a walk-in basis. See “Emergency care / urgent care” on pages 49-51 for coverage information.

Skilled nursing facilities

Skilled nursing facilities provide lower intensity rehab and medical services. Services at skilled nursing facilities are covered under the benefit for inpatient care (pages 60-62).

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 PLUS providers	With non-PLUS providers
☎ **Sleep studies**	PLUS deductible	Non-PLUS deductible and 20% coinsurance

☎ **Sleep studies need preapproval.**

Speech therapy

Services 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. The services must be ordered by a physician and provided in a hospital, clinic or private office.

	With PLUS providers	With non-PLUS providers
☎ **Speech therapy with autism diagnosis**	No member costs	Non-PLUS deductible and 20% coinsurance
☎ **All other speech therapy**	No member costs (limited to 20 visits in a plan year)	Non-PLUS deductible and 20% coinsurance (limited to 20 visits in a plan year)

Covered speech therapy services include:

- ❑ Assessment of and remedial services for speech defects caused by either a physical disorder or by autism spectrum disorder
- ❑ Speech rehabilitation, including physiotherapy, following laryngectomy

✕ Restrictions:

- There is no coverage for:
  - Cognitive rehabilitation
  - Language therapy for learning disabilities such as dyslexia
  - Voice therapy
  - Speech therapy to treat a chronic condition when that treatment is neither curative nor restorative
- Services provided in a school-based setting are not covered.
- The Plan does not cover services for developmental delays and disabilities that the law requires be provided by early intervention programs or schools. (Until age 3, children can get services under the benefit for early intervention programs. Then, Massachusetts Special Education Law (M.G.L. c. 71(b)) – known as Chapter 766 – requires Massachusetts school systems to provide services to address a child's disabilities. Similar laws apply in other states as well.)

☎ **Speech therapy services need preapproval.**

Surgery

The surgery benefit covers facility charges and surgeon fees for operative services including care before, during and after surgery. Your member costs depend on whether the surgery is inpatient or outpatient and on where you have the surgery.

☎ Inpatient hospital	With PLUS providers	With non-PLUS providers
Facility charges	$275/500/1,500 quarterly copay and PLUS deductible ($500 copay outside of MA)	$500 quarterly copay, non-PLUS deductible, and 20% coinsurance
Surgeon fees	PLUS deductible	Non-PLUS deductible and 20% coinsurance
☎ Outpatient hospital	**With PLUS providers**	**With non-PLUS providers**
Facility charges and surgeon fees	$110/110/250 quarterly copay and PLUS deductible ($110 copay outside of MA)	$110 quarterly copay, non-PLUS deductible, and 20% coinsurance
☎ Non-hospital-owned location	**With PLUS providers**	**With non-PLUS providers**
Facility charges and surgeon fees	PLUS deductible	Non-PLUS deductible and 20% coinsurance

Reconstructive breast surgery for all stages of mastectomy are covered under this benefit. See page 173 for details.

✕ Restrictions:

- Coverage for reconstructive and restorative surgery – 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
- 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.
- Cosmetic services are not covered, with the exception of treatment for HIV-associated lipodystrophy and the initial surgical procedure to correct appearance that has been damaged by an accidental injury.
- Coverage for assistant surgeon services is limited, as follows:
  - The services of an assistant surgeon must be medically necessary.
  - The assistant surgeon must be a licensed provider (e.g., physician, physician assistant) acting within the scope of his or her license and trained in a surgical specialty related to the procedure.
  - The assistant surgeon serves as the first assistant surgeon to the primary surgeon during a surgical procedure.
  - Only one assistant surgeon is covered per procedure. Second and third assistants are not covered.
  - Interns, residents and fellows are not covered as assistant surgeons.

☎ Surgical services may need preapproval.

Hip and knee replacement program

UniCare has established a program for members needing hip or knee replacement surgery. The program is designed to better coordinate the many different medical services that hip and knee replacements require, including the surgery as well as post-surgical services. Certain member costs, such as copays and coinsurance, may be reduced or waived for members who participate.

To learn more about this program, call UniCare Member Services at 833-663-4176.

Telehealth

Telehealth visits with primary care and specialty care providers are covered. See "Doctor and other medical provider services" on page 47 for coverage information.

Telehealth notice – Regulations concerning future telehealth benefits are currently under review in Massachusetts. For updates on telehealth services, requirements, and benefits, check unicaremass.com.

Tobacco cessation counseling

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

	With PLUS providers	With non-PLUS providers
Tobacco cessation counseling	No member costs (limited to 300 minutes in a plan year)	No member costs (limited to 300 minutes in a plan year)

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 face-to-face 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 claim forms from unicaremass.com.

Nicotine replacement products are available at no cost through the prescription drug plan, but you must have a prescription. See Part 4 of this handbook for details.

Restrictions:

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

Transplants

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

	With PLUS providers	With non-PLUS providers
☎ **At a Quality Center or Designated Hospital for transplants**	$275/500/1,500 quarterly copay and PLUS deductible	$275/500/1,500 quarterly copay and PLUS deductible
☎ **At other hospitals**	$275/500/1,500 quarterly copay, PLUS deductible, and 20% coinsurance	$500 quarterly copay, non-PLUS deductible, and 20% coinsurance

A UniCare primary clinician is available to support you and your family before the transplant procedure and throughout the recovery period. The primary clinician 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

☎ **Transplants need preapproval** – This requirement doesn't apply to cornea transplants.

Human organ donor services

Benefits are payable – subject to any deductibles, 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, and regulations established by the Massachusetts Department of Public Health.

Quality Centers and Designated Hospitals for transplants

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

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

Go to unicaremass.com for lists of these hospitals in Massachusetts and other states.

Travel clinics

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

	With PLUS providers	With non-PLUS providers
Travel clinic visits	No member costs	No member costs
Immunizations at travel clinics	No member costs	No member costs

Restrictions:

- Unless you are pregnant, there is no coverage for blood tests (titers) to determine if you need an immunization. See Immunization titers on page 95.

Urgent care

The Plan covers urgent care services. **Urgent care** refers to services you get when your health is not in serious danger but you need immediate medical attention. You can get urgent care services at various locations that offer walk-in medical care, but your member costs will vary. See “Emergency care / urgent care” on pages 49-51 to find out about the different types of providers that offer urgent care services.

Walk-in clinics

Walk-in clinics are sites that offer medical care on a walk-in basis, so no appointment is needed.
See “Emergency care / urgent care” on pages 49-51 for information about the different types of walk-in clinics.

Wigs

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

	With PLUS providers	With non-PLUS providers
Wigs	20% coinsurance	20% coinsurance

Restrictions:

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

Chapter 5: Covered behavioral health services

Summary of covered behavioral health services

Table 13. Summary of costs for behavioral health services

Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 27).

Service – Visits may be in-person or through telehealth	Member costs with PLUS providers	Member costs with non-PLUS providers	See page
Emergency service programs	No member costs	No member costs	78
☎ **Inpatient care**	$200 quarterly copay	$200 quarterly copay, non-PLUS deductible, and 20% coinsurance	79
Medication-assisted treatment (MAT)	No member costs	No member costs	80
Medication management (outpatient)	$15 copay	$20 copay and non-PLUS deductible	81
☎ **Office services**	$15 copay	$20 copay and non-PLUS deductible	81
☎ **Outpatient services**	PLUS deductible	Non-PLUS deductible and 20% coinsurance	82
Substance use disorder assessment / referral	No member costs	No member costs	83
Telehealth – See the telehealth notice on page 83 *When using LiveHealth Online or a PLUS provider, you don't owe a copay for the first three visits.*	▪ **LiveHealth Online:** $15 copay ▪ **Other PLUS providers:** Copay of the service being provided	Non-PLUS copay, deductible, and coinsurance of the service being provided	83
Therapy (outpatient)			84
▪ Individual therapy	$15 copay	$20 copay and non-PLUS deductible	
▪ Family therapy	$15 copay	$20 copay and non-PLUS deductible	
▪ Group therapy	$15 copay	$20 copay and non-PLUS deductible	

About behavioral health services

Behavioral health services are services that treat mental health and substance use disorder conditions. The Plan offers comprehensive benefits for behavioral health services. UniCare has partnered with **Beacon Health Options** to establish access to experienced behavioral health providers.

Your member costs for behavioral health services are lowest when you use PLUS providers. PLUS providers are contracted with Beacon Health Options to provide services to UniCare members. They have agreed to accept UniCare's payment as payment in full. This means they won't balance bill UniCare members. In addition, you have lower member costs when you use PLUS providers.

Important! Non-PLUS providers may balance bill you for charges over the allowed amount (that is, above the amount the Plan paid). This is true both in Massachusetts and out of state. See page 27 for information about balance billing protection in Massachusetts.

Your behavioral health benefits cover services to treat mental health and substance use disorders. These benefits include coverage for:

- ❑ Autism spectrum disorder
- ❑ Emergency care
- ❑ Inpatient care
- ❑ Medication-assisted treatment (MAT)
- ❑ Medication management
- ❑ Office services
- ❑ Outpatient services
- ❑ Substance use disorder assessments / referrals
- ❑ Telehealth visits
- ❑ Therapy

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.

Services for autism spectrum disorders are covered like any other behavioral health or physical condition. Coverage is subject to all pertinent provisions of the Plan, including use of participating providers, preapproval reviews, benefit limitations, and provider payment methods. Medical services needed for diagnosis and treatment are covered as a medical benefit.

Diagnosis and treatment of autism spectrum disorders may include (but are not limited to) the following services:

- ❑ **Applied Behavior Analysis (ABA)** – A specialized therapy used in the treatment of autism spectrum disorders that focuses on improving appropriate behaviors and minimizing negative behaviors. ABA is administered by a licensed clinician, such as a board-certified behavior analyst (BCBA), working in association with a paraprofessional. The licensed clinician performs an assessment and develops a treatment plan which is carried out by the paraprofessional. To be eligible for benefits, the paraprofessional must be supervised by the licensed clinician.

- ❑ **Psychiatric services** – Services that focus on treating behaviors that pose a danger to self, others and/or property or that impair daily functioning, such as:
  - Diagnostic evaluations and assessment
  - Treatment planning
  - Referral services
  - Medication management
  - Inpatient/24-hour supervisory care
  - Partial hospitalization/day treatment
  - Intensive outpatient treatment
  - Services at an acute residential treatment facility
  - Individual, family, therapeutic group, and provider-based case management services
  - Psychotherapy, consultation, and training session for parents
  - Paraprofessional and resource support for the family
  - Crisis intervention
  - Transitional care

Preapproval for autism spectrum disorder treatment – Physical therapy, occupational therapy, and speech therapy services to treat autism spectrum disorders do not require preapproval.

Emergency service programs

Important! Always seek emergency care if you (or someone covered under your Plan) present a significant risk to yourself or others. In a life-threatening emergency, go to the closest emergency room (see pages 49-51 for benefits information). If you call UniCare seeking non-life threatening emergency care, UniCare will connect you with appropriate services within six hours.

Seek urgent care if you have a condition that may become an emergency if it is not treated quickly. Call UniCare if you need help finding an available behavioral health provider. UniCare will help you schedule an appointment within 48 hours of your call.

In Massachusetts, **Emergency service programs (ESPs)** provide behavioral health crisis assessment, intervention and stabilization services on short notice. These programs are staffed by behavioral health providers who can evaluate a member in their home, office, or at some other community-based location, like a school. Evaluations can also be performed at a hospital emergency room, and many Massachusetts hospitals contact one of these programs if an ER patient needs behavioral health intervention.

	With PLUS providers	With non-PLUS providers
Emergency service programs in Massachusetts (ESP)	No member costs	No member costs

ESPs provide crisis assessment within one hour of being contacted. They will evaluate the member to determine what type of service is needed, and help access the service. For example, if a suicidal member calls an ESP, a provider will come to their location and perform an evaluation. If inpatient care is needed, the ESP will find a bed and get the necessary preapproval.

To contact an ESP, call 877-382-1609 and enter your Massachusetts ZIP code to get the toll-free number for the ESP in your area.

Restrictions:

- If you're admitted to a non-PLUS hospital from the emergency room and there aren't any PLUS hospitals available, you'll owe the PLUS inpatient copay (not the non-PLUS copay).
- UniCare will pay up to the non-PLUS allowed amount for services you get at a non-PLUS inpatient hospital. However, you may be responsible for paying charges over the allowed amount (that is, the hospital may balance bill you).

Notify UniCare if you're admitted to the hospital from the emergency room – Your provider should notify UniCare within 24 hours of your admission.

Inpatient services

Inpatient behavioral health services address behavioral health conditions with severe symptoms that are expected to improve with intensive, short-term treatment. These are services you get when staying overnight (that is, you've been admitted) at an acute care hospital, psychiatric hospital, substance use disorder facility, or residential facility. Most of these services are available for both adults and adolescents, unless otherwise noted.

	With PLUS providers	With non-PLUS providers
Inpatient services	$200 quarterly copay	$200 quarterly copay, non-PLUS deductible, and 20% coinsurance

Table 14 lists the services and programs covered under this benefit.

Table 14. Behavioral health inpatient services

Inpatient service	Description
Acute residential treatment	Short-term, 24-hour programs that provide treatment within a protected and structured environment
Acute residential withdrawal management [ASAM level 3.7 detox]	Drug or alcohol withdrawal (detox) that is medically monitored, for members at risk of severe withdrawal
Clinical stabilization services for substance use disorder (CSS) [ASAM level 3.5]	Clinically-managed detox and recovery services provided in a non-medical setting
Community-based acute treatment (CBAT)	Treatment for children and adolescents with serious behavioral health disorders who need a protected and structured environment
Crisis stabilization units (CSU)	24-hour observation and supervision when inpatient hospital care isn't needed
Dual diagnosis acute treatment (DDAT) [ASAM level 3.5]	Clinically-managed detox and recovery services for those with both a substance use and mental health condition who require a protected and structured environment
Inpatient psychiatric services	Admission to an acute care hospital or psychiatric hospital for treatment of a mental health condition
Inpatient substance use disorder services, medically managed [ASAM level 4 detox]	24-hour medical care for substance withdrawal provided at an acute care hospital

Inpatient service	Description
Observation stays	A hospital stay that allows for extended assessment or observation when an inpatient admission may not be appropriate or needed. Observation stays typically last 24 hours or less, but can be for up to 72 hours.
Transitional care units (TCU)	Facilities that help children and adolescents transition from an acute care facility to home, a residential program, or foster care

Restrictions:

- If you're admitted to a non-PLUS hospital from the emergency room and there aren't any PLUS hospitals available, you'll owe the PLUS inpatient copay (not the non-PLUS copay).
- There's no coverage for non-acute residential treatment. Examples of such treatment include:
  - Clinically-managed, low-intensity residential services
  - Clinically-managed, population-specific, high-intensity residential services
  - Recovery residences
  - Sober homes
- There's no coverage for treatment performed in a non-conventional setting. Examples of non-conventional settings include:
  - Spas or resorts
  - Therapeutic or residential schools
  - Educational, vocational, or recreational locations
  - Day care or preschools
  - Outward Bound
  - Wilderness, camp or ranch programs

Behavioral health inpatient services may need preapproval – Your provider should notify UniCare when you get behavioral health inpatient services. See the list of behavioral health preapproval requirements on pages 30-31.

Medication-assisted treatment (MAT)

The Plan covers **medication-assisted treatment (MAT)**, the long-term prescribing of medication as an alternative to the opioid on which a member was dependent. This treatment is usually dispensed through **opiate treatment programs (OTP)** that are licensed to distribute and administer these medications.

	With PLUS providers	With non-PLUS providers
Medication-assisted treatment from opiate treatment programs	No member costs	No member costs

When you get this treatment through an OTP, both the drug and its administration are covered at no member cost. You can also get this treatment from a provider in an office setting, but in that case you will be responsible for the member costs associated with a provider visit.

Important! You owe costs for an office visit when you get MAT from an individual provider. In addition, you'll need to fill a prescription for the medication at a pharmacy.

Medications covered under this benefit include methadone, buprenorphine (Suboxone), and naltrexone (Vivitrol).

Medication management (outpatient)

The Plan covers medication management visits, including medication management visits that include outpatient therapy. **Medication management** consists of visits with a behavioral health provider who can evaluate and prescribe medication, if needed. These services may be handled in person or through telehealth.

	With PLUS providers	With non-PLUS providers
Medication management	$15 copay	$20 copay and non-PLUS deductible

Medication management also includes **ambulatory withdrawal management**, more commonly known as **outpatient detox**. Ambulatory withdrawal management is a drug or alcohol withdrawal process in which a member has daily visits with a provider throughout withdrawal.

Office services

The Plan covers medically necessary office services to treat mental health and substance use disorder conditions. These services must be provided in an appropriate setting such as a medical office, home, hospital, other medical facility, or through telehealth.

	With PLUS providers	With non-PLUS providers
☎ **Office services**	$15 copay	$20 copay and non-PLUS deductible

Covered office services include the services and programs listed in Table 15.

Table 15. Behavioral health office services

Office service	Description
Acupuncture withdrawal management (detox)	The use of acupuncture to ease the symptoms of drug or alcohol withdrawal
Applied Behavior Analysis (ABA)	Specialized therapy used to treat autism spectrum disorders that focuses on improving appropriate behaviors and minimizing negative behaviors
Dialectical behavioral therapy (DBT)	A combination of therapies designed to help change unhealthy behaviors and treat people suffering from behavioral health disorders
Neuropsychological testing	Testing to find out if a problem with the brain is affecting one's ability to reason, concentrate, solve problems, or remember
Psychiatric visiting nurse (VNA) services	Short-term treatment delivered in the home or living environment to treat behavioral health disorders with medication
Psychological testing	Standardized assessment tools to diagnose and assess overall psychological functioning
Transcranial magnetic stimulation (TMS)	A non-invasive method of brain stimulation used to treat major depression

Restrictions:

- If you have more than one office service from the same provider on the same day, you only owe one copay. If the copays that apply to the services differ, you owe the higher copay.
- There is no coverage for testing for developmental delays of school-aged children. This is considered educational testing and may be covered by the school system (under Chapter 766 in Massachusetts or similar laws in other states).

Behavioral health office services may need preapproval – Your provider should contact UniCare if you will be having behavioral health office services. See the list of behavioral health preapproval requirements on pages 30-31.

Outpatient services

Outpatient services for behavioral health conditions don't require an inpatient hospital admission or overnight stay, but they do require more intensive support than other kinds of behavioral health care. Most of these services are available for both adults and adolescents, unless otherwise noted.

	With PLUS providers	With non-PLUS providers
Outpatient services	PLUS deductible	Non-PLUS deductible and 20% coinsurance

Table 16 lists the outpatient services covered under this benefit.

Table 16. Behavioral health outpatient services

Outpatient service	Description
Community support programs (CSP)	Programs to help members access and use behavioral health services
Day treatment	Behavioral health programs offering structured, goal-oriented treatment that focuses on improving one's ability to function in the community
Electroconvulsive therapy (ECT)	Psychiatric treatment in which seizures are electrically induced in patients to provide relief from mental disorders
Family stabilization teams (FST)	Programs offering intensive services in the home to help children, adolescents and their families deal with complex life stressors
Intensive outpatient programs (IOP) ▪ For mental health ▪ For substance use disorder [ASAM level 2.1]	Programs that offer thorough, regularly-scheduled treatment in a structured environment. These programs offer at least three hours of therapy a day, up to seven days a week
Partial hospitalization programs (PHP) ▪ For mental health ▪ For substance use disorder [ASAM level 2.5]	Non-residential, structured outpatient psychiatric and substance use programs that are more intensive than one would get in a doctor's office, but that are an alternative to inpatient care. These programs offer at least five hours of therapy a day, up to seven days a week.

Outpatient service	Description
Structured outpatient addictions programs (SOAP)	Non-residential, structured substance use disorder programs that are more intensive than one would get in a doctor's office, but that are an alternative to inpatient care. These programs offer at least three hours of therapy a day, up to seven days a week.

Restrictions:

- There's no coverage for treatment performed in a non-conventional setting. Examples of non-conventional settings include:
  - Spas or resorts
  - Therapeutic or residential schools
  - Educational, vocational, or recreational locations
  - Day care or preschools
  - Outward Bound
  - Wilderness, camp or ranch programs

Behavioral health outpatient services may need preapproval – Your provider should contact UniCare if you will be having outpatient services for a behavioral health condition. See the list of behavioral health preapproval requirements on pages 30-31.

Substance use disorder assessment / referral

Substance use disorder assessment/referral is a comprehensive assessment of substance use to allow a provider to refer a member to appropriate care.

	With PLUS providers	With non-PLUS providers
Substance use disorder assessment / referral	No member costs	No member costs

Telehealth

The Plan covers counseling and medication management services that take place by telephone, mobile device, or computer using telehealth (audio and audiovisual) technology.

Telehealth notice – Regulations concerning future telehealth benefits are currently under review in Massachusetts. For updates on telehealth services, requirements, and benefits, check unicaremass.com.

	With PLUS providers	With non-PLUS providers
Telehealth *When using LiveHealth Online or a contracted provider, you don't owe a copay for the first three visits.*	▪ **LiveHealth Online:** $15 copay ▪ **Other PLUS providers:** Copay of the service being provided	Non-PLUS copay, deductible, and coinsurance of the service being provided

Therapy (outpatient)

The Plan covers medically necessary individual, family, and group therapy. Medication management performed in combination with therapy is also covered. These services must be provided in an appropriate setting such as a medical office, home, hospital, other medical facility, or through telehealth.

	With PLUS providers	With non-PLUS providers
Individual therapy	$15 copay	$20 copay and non-PLUS deductible
Family therapy	$15 copay	$20 copay and non-PLUS deductible
Group therapy	$15 copay	$20 copay and non-PLUS deductible

Restrictions:

- If you have more than one type of therapy on the same day and from the same provider, you only owe one copay. If the copays that apply to the services differ, you owe the higher copay.
- Family and individual therapy must be conducted in a provider's office, a facility or, if appropriate, at a member's home.
- Group therapy sessions must be 50 minutes or less.

Chapter 6: Covered preventive services

The Plan covers preventive or routine office visits, physical exams and other related preventive services listed in Table 17. Covered preventive services include those services recommended by the U.S. Preventive Services Task Force as part of the Patient Protection and Affordable Care Act (PPACA), the healthcare reform legislation that was passed in March 2010. Preventive exams are covered according to the schedule issued by Massachusetts Health Quality Partners.

The preventive services listed here are covered at 100% of the allowed amount, subject to the gender, age and limits shown in the table.

Your doctor must submit claims with preventive diagnosis and procedure codes to be covered at 100% as a preventive service. Preventive services don't include services to treat an existing condition. If, during your preventive visit, you get services to treat an existing condition, you may owe member costs for those services.

Please note that the preventive services listed here are not recommended for everyone. You and your doctor should decide what care is appropriate for you.

Table 17. Preventive care schedule

Preventive service	Males	Females	Age	How often / limits
Abdominal aortic aneurysm screening	■	■	65 and older	One time
Alcohol misuse screening and counseling	■	■		Part of the preventive exam
Anemia screening		■		Part of the preventive exam
Aspirin to prevent cardiovascular disease and colorectal cancer	■	■		Subject to your prescription drug benefit
Blood pressure screening	■	■		Part of the preventive exam
Bone density testing – Screening for osteoporosis		■	40 and older	Every 2 years
☎ **BRCA risk assessment and genetic counseling / testing –** For breast cancer		■		One time
Breast cancer counseling and preventive medications		■		Part of the preventive exam
Breastfeeding counseling		■		Part of the preventive exam
Cardiovascular disease prevention – Nutritional and physical activity counseling	■	■		For high-risk adults; part of the preventive exam
Chlamydia screening		■		Every 12 months
Cholesterol screening	■	■		Every 12 months

Preventive service	Males	Females	Age	How often / limits
Colorectal cancer screening – Includes colonoscopies, fecal occult blood testing, and other related services and tests Colonoscopies for members under 45 are covered under limited circumstances (see page 92) ☎ Virtual colonoscopies need preapproval	■	■	45 and older	▪ Every 5 years (60 months) ▪ Every 12 months for fecal occult blood test
Depression screening – Includes screening for perinatal depression (during and after pregnancy)	■	■		Part of the preventive exam
Developmental and behavioral screening	■	■		Part of the preventive exam for children
Diabetes screenings: ▪ Type 2 diabetes ▪ Gestational diabetes in pregnant women	■	■		Part of the preventive exam
Domestic violence screening		■		For women of childbearing age; part of the preventive exam
Drug use screening	■	■		Part of the preventive exam
Falls prevention – Vitamin D counseling and/or physical therapy	■	■	65 and over	For at-risk community-dwelling adults; counseling is part of the preventive exam
Fluoride supplements – Starting at the age of primary tooth eruption	■	■	Up to age 5	
Folic acid supplements – To help prevent birth defects		■		Subject to your prescription drug benefit
Gonorrhea preventive medication	■	■	At birth	For newborns
Gonorrhea screening		■		Every 12 months
Gynecological exams		■		Every 12 months
Hearing screening	■	■	At birth	For newborns
Height, weight and body mass index (BMI) measurements	■	■		Part of the preventive exam
Hepatitis B screening	■	■		
Hepatitis C screening	■	■		
HIV screening – For the virus that causes AIDS	■	■		
HPV (human papillomavirus) testing – For cervical cancer		■	30 and older	Every 5 years for women with normal cytology results
Hypothyroidism screening	■	■	At birth	For newborns
Immunizations	■	■		
Iron supplements for anemia	■	■	6 to 12 months	For at-risk babies

Preventive service	Males	Females	Age	How often / limits
Lab tests – Other covered screening lab tests: ▪ Hemoglobin ▪ Urinalysis ▪ Chemistry profile, including: ▫ Complete blood count (CBC) ▫ Glucose ▫ Blood urea nitrogen (BUN) ▫ Creatinine transferase alanine amino (SGPT) ▫ Transferase asparate amino (SGOT) ▫ Thyroid stimulating hormone (TSH)	■	■		Part of the preventive exam
Lead exposure screening	■	■		For children
Lung cancer scan – CT lung scan for adults who have smoked	■	■	50-80 years	Every 12 months
Mammograms – Screening for breast cancer		■	35 and older	▪ Once between the ages of 35 and 40 ▪ Yearly after age 40
Nutritional counseling	■	■		For children at high risk of obesity
Obesity screening and counseling	■	■		Part of the preventive exam
Oral health assessment	■	■		Part of the preventive exam for children
Pap smears – Screening for cervical cancer		■		Every 12 months
Phenylketonuria (PKU) screening	■	■	At birth	For newborns
Preeclampsia screening and prevention		■		During pregnancy; part of the preventive exam
Preventive exams (children)	■	■	Up to age 19	▪ Four exams while the newborn is in the hospital ▪ Five exams 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 service	Males	Females	Age	How often / limits
Preventive exams (adults)	■	■	19 and older	Every 12 months
Prostate cancer screening – Digital rectal exam and PSA test	■		50 and older	▪ Digital exam – Part of the preventive exam ▪ PSA test – Every 12 months
Rh incompatibility screening		■		For pregnant women
Sexually transmitted infections (STI) counseling	■	■		Part of the preventive exam
Sickle cell disease screening	■	■	At birth	For newborns
Skin cancer behavioral counseling	■	■		Part of the preventive exam
Syphilis screening	■	■		
Tobacco use counseling and interventions	■	■		▪ Counseling – Part of the preventive exam ▪ Drugs and deterrents – Subject to your prescription drug benefit
Tuberculosis screening	■	■		
Urinary tract infections (UTI) screening – Asymptomatic bacteriuria		■		During pregnancy
Vision screening	■	■		Part of the preventive exam for children
Vision screening (instrument-based)	■	■	3-5 years	

PART 3:

USING YOUR PLAN

Plan and coverage details

For questions about any of the information in Part 3 of this handbook, please call UniCare Member Services at 833-663-4176.

Administered by

UniCare

Chapter 7: Excluded and limited services

This chapter lists services and supplies that are not covered or have limited or restricted coverage under the Plan.

Important! Costs for services that the Plan doesn't cover don't count toward your deductible or your out-of-pocket maximums. Member costs (like the deductible) and out-of-pocket maximums only apply to covered services.

Table 18. Excluded, restricted and limited benefits

Service	What is not covered or has limited coverage
A	
Acne-related services	No coverage for the removal of acne cysts, injections to raise acne scars, cosmetic surgery, dermabrasion or similar services. Services to diagnose or treat the underlying condition causing the acne are covered.
Acupuncture	Covered only as a behavioral health service when acupuncture is used as part of drug withdrawal management
Allowed amounts	No coverage for charges over the Plan's allowed amounts
Alternative treatments	No coverage for alternative treatments that are used in place of conventional medicine, as defined by the National Center for Complementary and Integrative Health (National Institutes of Health)
Ambulances	Ambulance services are limited to transportation in the case of a medical emergency to the nearest hospital that can treat the condition. The following restrictions apply: ▪ Inter-facility transfers by ground ambulance are only covered if you are in a facility that cannot treat your condition or when needed to support discharge planning to a lower level of care; in both cases, the transfer is limited to the nearest facility that can provide treatment. ▪ Inter-facility transfers by air or sea ambulance must be medically necessary and are only covered if you are in a facility that cannot treat your condition; the transfer is limited to the nearest facility that can provide emergency treatment. ▪ Transfers to a hospital that you prefer (e.g., to be closer to home) are not covered. ▪ Transportation to scheduled appointments (such as dialysis treatment) is not covered because it is not considered an emergency. ▪ Transportation in chair cars or vans is not covered. ▪ There is no coverage for charges when ambulance calls are refused.
Anesthesia for behavioral health services	Covered for electroconvulsive therapy (ECT) only
Animals	No coverage for expenses related to service animals, pet therapy, or hippotherapy (therapeutic or rehabilitative horseback riding)

Service	What is not covered or has limited coverage
Arch supports (e.g., Dr. Scholl's inserts)	Not covered
Assistant surgeons	▪ An assistant surgeon must be a licensed provider (e.g., physician, physician assistant) acting within the scope of his or her license. ▪ Only one assistant surgeon per procedure is covered. Second and third assistants are not covered. ▪ Interns, residents and fellows are not covered as assistant surgeons.
Athletic trainer services	Not covered
B	
Beds / bedding	No coverage for non-hospital beds, orthopedic mattresses, or weighted blankets
Behavioral health services	▪ Primary care visits associated with a behavioral health diagnosis are covered. Otherwise, there is no coverage for the diagnosis, treatment or management of mental health/substance use disorder conditions by medical (non-behavioral health) providers. ▪ No coverage of services for conditions that are not classified in the most current edition of the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) ▪ Other non-covered behavioral health services include: ▫ Services not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance use disorder ▫ Services not consistent with prevailing national standards of clinical practice for the treatment of such conditions ▫ Services not consistent with prevailing professional research which would demonstrate that the service or supplies will have a measurable and beneficial health outcome ▫ Services that typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; or that are consistent with appropriate level-of-care clinical criteria, clinical practice guidelines or best practices as modified from time to time.
Biofeedback	Not covered to treat behavioral health conditions
Blood	The Plan does not pay for donated blood
Blood pressure cuffs (sphygmomanometers)	Not covered
C	
Cardiac rehab programs	Covered only when started within six months of a cardiac event
Chair cars / vans	No coverage for transportation in chair cars or vans
Chiropractic care	▪ Group chiropractic care is not covered. ▪ Services provided by a chiropractor are considered chiropractic care, not physical therapy.

Service	What is not covered or has limited coverage
Chronic conditions	There is no coverage for physical therapy, occupational therapy or speech therapy to treat a chronic condition when that treatment is neither curative nor restorative
Clinical trials for treatments other than cancer	No coverage for any clinical research trial other than a qualified clinical trial for the treatment of cancer (pages 42-43)
Cognitive rehabilitation	Not covered **Cognitive rehabilitation** is treatment to restore function or minimize effects of cognitive deficits including, but not limited to, those related to thinking, learning and memory.
Colonoscopies for people under age 45	Covered as a preventive service only under limited circumstances, based on clinical review of family and personal history
Computer-assisted communications devices	Not covered
Convenience items	No coverage for convenience items used during a hospital stay, such as telephones, television, computers, and beauty or barber services
Cosmetic services	No coverage for cosmetic procedures or services except for: ▪ Treatment for HIV-associated lipodystrophy ▪ 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. **Cosmetic services** are services done mainly to improve appearance. They don't restore bodily function or correct functional impairment.
Coverage under another plan or program	No coverage for services provided under another plan, or services that federal, state or local law mandates must be provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.
Custodial care	Not covered **Custodial care** is a level of care that is chiefly designed to assist with activities of daily living and that cannot reasonably be expected to greatly restore physical health or bodily function.
D	
Dialysis	No coverage for dialysis to treat a behavioral health condition
Dental care	The Plan does not provide benefits for dental care. Medical services that include treatment related to dental care are covered in certain situations (page 44).
Dentures, dental prosthetics and related surgery	Not covered
Driving evaluations	Not covered
Drugs – Non-oncology infused	Dispensed by the prescription drug plan and require prior review (Part 4 of this handbook).

Service	What is not covered or has limited coverage
Drugs – Off-label	Not covered unless the off-label use meets the Plan's definition of medical necessity or the drug is specifically designated as covered by the Plan. **Off-label** use is the use of a drug for a purpose other than that approved by the FDA.
Drugs – Over-the-counter	Not generally covered and never covered without a prescription. Some over-the-counter drugs, such as tobacco cessation products, are covered by the prescription drug plan when you have a prescription (Part 4 of this handbook).
Drugs – Specialty	Some specialty drugs are covered by UniCare and must be preapproved. Preapproval is described on pages 28-31. Other self- or office-administered specialty drugs are dispensed under the prescription drug plan (Part 4 of this handbook). **Specialty drugs** are certain pharmaceutical and/or biotech or biological drugs (including "biosimilars" or "follow-on biologics") used in the management of chronic or genetic disease. Specialty drugs include, but are not limited to, injectables, infused, inhaled or oral medications, or those that otherwise require special handling.
Duplicate (redundant) services	No coverage for multiple charges for the same service or procedure, on the same date A service is considered duplicate (redundant) when the same service is being provided, at the same time, to treat the condition for which it is ordered.
Durable medical equipment (DME)	Only medically necessary equipment is covered. Types of equipment that are not covered include: ▪ Equipment intended for athletic or recreational use (e.g., exercise equipment, wheelchairs for sports) ▪ Items intended for environmental control or a home modification (e.g., bathroom items, electronic door openers, air cleaners, dehumidifiers, elevators, ramps, stairway lifts) ▪ Added, non-standard features or accessories (e.g., hand controls for driving, transit systems that secure wheelchairs in moving vehicles, wheelchair customizations) ▪ Items specifically designed to be used outdoors (e.g., special wheelchairs for beach access, equipment for use on rough terrain) ▪ Items that serve as backup by duplicating other equipment (e.g., a manual wheelchair as backup for a powered wheelchair) ▪ Equipment upgrades or replacements for items that function properly or that can be repaired
E	
Ear molds	Not covered except when needed for hearing aids for members age 21 and under
EKG (electrocardiogram)	Not covered when done as a screening or preventive service

Service	What is not covered or has limited coverage
Enteral therapy	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. **Enteral therapy** is prescribed nutrition that is administered through a tube that has been inserted into the stomach or intestines.
Equipment transportation and set-up	No coverage for costs associated with transporting and setting up equipment, such as portable X-ray equipment.
Exercise / recreational equipment	No coverage for equipment intended for athletic or recreational use (e.g., exercise equipment, wheelchairs for sports).
Experimental or investigational services or supplies	No coverage for a service or supply that the Plan determines is 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 is being tried after others have failed, does not make it medically necessary.
Eyeglasses and contact lenses	▪ Only covered within six months after an eye injury or cataract surgery ▪ Coverage applies to the initial lenses only ▪ No coverage for deluxe frames or specialty lenses such as progressive or transitional lenses, tinted lenses, anti-reflective coating or polycarbonate lenses
F	
Facility fees	Not covered for office visits or behavioral health office services
Family members	No coverage for services received from someone who is in your immediate family. Your immediate family consists of you, your spouse and your children, as well as the brothers, sisters and parents of both you and your spouse. This includes any services that providers perform on themselves.
Fees for non-medical services	Fees for non-medical services are not covered. Some examples of these types of fees include: ▪ Day care services ▪ Food services (e.g., diet programs) ▪ Lab handling fees ▪ Membership and joining fees (e.g., Weight Watchers), with the exception of the fitness reimbursement ▪ Record processing fees, unless required by law ▪ Shipping costs (e.g., the cost of shipping eggs or sperm between fertility clinics) ▪ Storage fees ▪ Transportation and set-up costs (e.g., portable X-ray equipment)

Service	What is not covered or has limited coverage
Fitness reimbursement	▪ Any family member may have the fitness membership, but the reimbursement is paid to the plan enrollee only. ▪ You must participate in physical activity an average of four times or more per month. ▪ Ineligible costs include beach or country club memberships or dues; fees for one-day events; annual or day passes (such as for skiing); spas or spa services; personal or home fitness equipment.
Free or no-cost services	▪ No coverage for any medical service or supply that wouldn't have cost anything if there was no medical insurance ▪ No coverage for services that you have no legal responsibility to pay
G	
Genetic testing for behavioral prescribing	Not covered
Government programs	There's 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
Group therapies	There is no coverage for: ▪ Group chiropractic care ▪ Group occupational therapy ▪ Group physical therapy
H	
Hearing aid batteries	Not covered
Herbal medicine	Not covered
Home modifications or environmental controls	No coverage for items intended for environmental control or home modification such as bathroom items, electronic door openers, air cleaners, dehumidifiers, elevators, ramps, and stairway lifts
Homemaking services	Not covered
Homeopathic / holistic / naturopathic care	Not covered
Household residents	No coverage for services received from anyone who shares your legal residence
Hypnotherapy	Not covered
I	
Immunization titers	Covered for pregnant women only **Immunization titers** are lab tests performed to determine if a person has had a vaccination.

Service	What is not covered or has limited coverage
Incontinence supplies	Not covered
Infertility treatment	▪ In vitro fertilization is limited to five attempts per lifetime. (Other infertility procedures, such as artificial insemination, are not limited.) ▪ Experimental infertility procedures are not covered. ▪ The Plan does not pay people to donate their eggs or sperm. ▪ 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 are covered only for the treatment of infertility. ▪ Storage fees for storing or banking sperm, eggs, and/or inseminated eggs are covered only when provided as part of gender reassignment treatment, and are limited to a maximum of 90 days in storage. ▪ The Plan does not pay people to be surrogates (gestational carriers) for UniCare plan members, and there is no coverage for medical services, including in vitro fertilization, for a surrogate who is not a UniCare member.
Intraocular lenses (IOLs)	Monofocal intraocular lenses (IOLs) are covered when implanted in the eye after the removal of cataracts. Presbyopia-correcting IOLs, which restore vision in a range of distances, are not covered. Multifocal IOLs and accommodating IOLs are presbyopia-correcting IOLs and are also not covered.
L	
Language therapy for learning disabilities	Not covered
Legally-mandated services for children	The Plan does not cover services for developmental delays and disabilities that the law requires be provided by early intervention programs or schools. (Until age 3, children can get services under the benefit for early intervention programs. Then, Massachusetts Special Education Law (M.G.L. c. 71(b)) – known as Chapter 766 – requires Massachusetts school systems to provide services to address a child's disabilities. Similar laws apply in other states as well.)
Lift / riser chairs	Not covered
Light boxes	Covered only for treatment of skin conditions
Long-term maintenance care and long-term therapy	Not covered
M	
Massage therapy	No coverage for massage therapy or any other services from a massage therapist or neuromuscular therapist
Mastectomy bras	Limited to two bras every two years, unless you need a new bra because your prosthesis has changed. Supporting documentation is required.

Service	What is not covered or has limited coverage
Medical necessity	There is no coverage for any treatment that is not medically necessary. The only exceptions to this requirement 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 doctor (Chapter 6) ▪ A service or supply that qualifies as covered hospice care (pages 57-58)
Medical orders	There is no coverage for any service or supply that has not been recommended and approved by a physician. All covered services and supplies need a medical order from a physician.
Military service or wartime injuries	No coverage for services to treat a condition that was the result of war (declared or undeclared), or service in the armed forces of any country if you are legally entitled to other benefits (such as through the Veterans Administration)
Missed appointments	Not covered
Molding helmets	No coverage for molding helmets or adjustable bands intended to mold the shape of the cranium
N	
Narconon treatment and facilities	Not covered
Neuropsych testing for ADHD	No coverage for neuropsych testing to diagnose attention-deficit hyperactivity disorder (ADHD)
Newborn admissions	If a newborn is admitted to the hospital independently of the mother, it is considered a separate hospital admission and you will owe a separate inpatient copay.
Non-conventional behavioral health treatments	No coverage for non-conventional behavioral health treatments. Examples of non-conventional treatments include: ▪ Aversive or counter-conditioning ▪ Brain imaging or mapping to diagnose behavioral health disorders ▪ Hemodialysis ▪ Olfactory/gustatory release ▪ Primal therapy ▪ Prometa (GABASYNC) treatment protocol ▪ Rolfing ▪ Structural Integration

Service	What is not covered or has limited coverage
Non-conventional treatment settings	No coverage for treatment performed in a non-conventional setting. Examples of non-conventional settings include: ▪ Spas or resorts ▪ Therapeutic or residential schools ▪ Educational, vocational, or recreational locations ▪ Day care or preschools ▪ Outward Bound ▪ Wilderness, camp or ranch programs
Non-covered services and associated services	Non-covered services include those for which there is no benefit and those that the Plan has determined to be not medically necessary. If a service is not covered by the Plan, any associated services are also not covered. For example, anesthesia and facility fees associated with a non-covered surgery are not covered.
Nutritional counseling	Services or counseling (therapy) must be performed by a registered dietician and are only covered for: ▪ Adults who are overweight or obese and who are at high risk for cardiovascular disease (Chapter 6) ▪ Children who are overweight or obese (Chapter 6) ▪ Children under 18 with cleft lip/palate (page 42) ▪ Members with certain eating disorders ▪ Members with diabetes (page 44)
Nutritional supplements (oral)	No coverage for nutritional supplements 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
O	
Occupational therapy	No coverage for group occupational therapy
Orthodontic treatment	Not covered
Orthopedic mattresses	Not covered
Orthotics	No coverage for temporary or trial orthotics, video tape gait analysis, diagnostic scanning, or arch supports
Oxygen equipment for travel	No coverage for oxygen equipment required for use on an airplane or other means of travel
P	
Park admissions	No coverage for admissions fees to national parks or preserves
Pastoral counselors	Covered for bereavement counseling, or when required by law

Service	What is not covered or has limited coverage
Personal items	No coverage for personal items that could be purchased without a prescription (e.g., air conditioners, arch supports, bed pans, bathroom items, blood pressure cuffs, commodes, computer-assisted communications devices, corrective shoes, heating pads, hot water bottles, incontinence supplies, lift or riser chairs, molding helmets, non-hospital beds, orthopedic mattresses, shower chairs, telephones, televisions, thermal therapy devices, whirlpools)
Physical therapy	▪ No coverage for certain therapy services including, but not limited to: acupuncture, aerobic exercise, craniosacral therapy, diathermy, infrared therapy, kinetic therapy, microwave therapy, paraffin treatment, Rolfing therapy, Shiatsu, sports conditioning, ultraviolet therapy, and weight training. ▪ No coverage for group physical therapy
Private duty nursing	No coverage in any inpatient facility, including acute care hospitals
Programs with multiple services	No coverage for 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). Itemized bills are always required.
Providers	▪ No coverage for services from providers who have been sanctioned ▪ No coverage for services from unlicensed providers ▪ No coverage for services outside the scope of a provider's license
R	
Reiki therapy	Not covered Reiki is a hands-on energy-based therapy.
Religious facilities	No coverage for services received at non-medical religious facilities
Residential treatment for behavioral health services	No coverage for non-acute residential treatment. Examples of such treatment include: ▪ Clinically-managed, low-intensity residential services ▪ Clinically-managed, population-specific, high-intensity residential services ▪ Recovery residences ▪ Sober homes
Respite care	Limited to a total of five days each plan year. Respite care is covered in a hospital, a skilled nursing facility, a nursing home or in the home.
Routine screenings	No coverage except according to the preventive care schedule (Chapter 6)
S	
School services	The Plan does not cover services for developmental delays and disabilities that the law requires be provided by early intervention programs or schools. (Until age 3, children can get services under the benefit for early intervention programs. Then, Massachusetts Special Education Law (M.G.L. c. 71(b)) – known as Chapter 766 – requires Massachusetts school systems to provide services to address a child's disabilities. Similar laws apply in other states as well.)

Service	What is not covered or has limited coverage
Sensory integration therapy	Not covered
Serious preventable adverse events	Costs associated with serious preventable adverse healthcare events are not covered, in accordance with Department of Public Health (DPH) regulations. Massachusetts providers are not permitted to bill members for designated serious reportable healthcare events.
Shingles vaccine	Covered only for members age 50 and older
Shipping costs	No coverage for shipping costs, such as the cost of shipping eggs or sperm between fertility clinics
Shoes	No coverage for shoes, including special shoes purchased to accommodate orthotics or to wear after foot surgery, except for: ▪ Therapeutic shoes for the prevention of complications associated with diabetes (limited to one pair each year) ▪ Orthopedic shoes that attach directly to a brace
Stairway lifts and stair ramps	Not covered
Stimulators / stimulation treatments	Transcranial magnetic stimulation is covered under your behavioral health benefit. Otherwise, there is no coverage for stimulators or stimulation treatments, including: ▪ Alpha-Stim cranial electrotherapy stimulator ▪ Fischer Wallace neurostimulators ▪ Vagus nerve stimulation
Storage for blood / bodily fluids	No coverage for the storage of autologous blood donations or other bodily fluids or specimens, except when done in conjunction with a scheduled covered procedure
Surface electromyography (SEMG)	Not covered
T	
Therapy (behavioral health)	▪ Group therapy sessions must be 50 minutes or less ▪ Family and individual therapy must be conducted in a provider's office, a facility or, if appropriate, at a member's home
Thermal therapy	No coverage for any type of thermal therapy, including the application or purchasing of hot packs, cold packs or continuous thermal therapy devices
Third parties	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.
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.

Service	What is not covered or has limited coverage
Tobacco cessation counseling	Limited to 300 minutes each plan year. Counseling is also covered as part of your preventive exam.
Transportation to/from appointments	Transportation to the place where you will be receiving hospice services is covered. There is no coverage for any other transportation to or from scheduled appointments.
Travel time	No coverage for travel time to or from medical appointments
V	
Vision correction	No coverage for surgery to correct refractive errors (visual acuity problems). Non-covered services include orthoptics for vision correction, radial keratotomy, and other laser surgeries. Refractive errors include astigmatism, myopia (near-sightedness), hyperopia (far-sightedness), and presbyopia (aging-related blurry vision).
Vision therapy	Not covered
Voice therapy	Not covered
W	
Weight loss	▪ Physician services for weight loss treatment are limited to members whose body mass index (BMI) is 40 or more while under the care of a physician. Any such treatment is subject to periodic review. ▪ No coverage for residential inpatient weight loss programs ▪ No coverage for membership fees and food items used to participate in a commercial weight loss program
Wheelchair transit systems	No coverage for transit systems used to secure wheelchairs in moving vehicles.
Wigs	Not covered for any purpose other than the replacement of hair loss resulting from treatment of any form of cancer or leukemia
Worker's compensation	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.
Worksite evaluations	No coverage for exams performed by a physical therapist to evaluate a member's ability to return to work
X	
X-ray equipment (portable)	No coverage for costs associated with transporting and setting up portable X-ray equipment.

Chapter 8: About your plan and coverage

Types of healthcare providers

What is a healthcare provider? A healthcare **provider** is a person, place, or organization that delivers healthcare services or supplies. A provider can be a **person** (like a doctor), a **place** (like a hospital), or an **organization** (like hospice).

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.

PLUS providers

You get the highest benefit when you use **PLUS providers** for your care. PLUS providers are:

- ❑ All physicians, hospitals, and ambulatory surgery centers in Massachusetts
- ❑ UniCare preferred vendors
- ❑ Contracted behavioral health providers
- ❑ Contracted specialized health facilities in Massachusetts (such as dialysis centers)
- ❑ Contracted providers outside of Massachusetts
- ❑ LiveHealth Online telehealth 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 doctor who is familiar with you and your healthcare needs. Your PCP can help you understand and coordinate care you get from other providers, such as specialists, who may not know you as well.

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

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

Enhanced Personal Health Care practices

Many PCPs in Massachusetts belong to practices that are in UniCare's Enhanced Personal Health Care program.

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

As a PLUS member, your primary care visit copay is lowest when you select a PCP who belongs to an Enhanced Personal Health Care practice.

Find more information about Enhanced Personal Health Care at unicaremass.com.

Specialists

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

As a UniCare member, you don't need a referral to see a specialist. When you do seek specialty care, you'll have lower office visit copays when you use Tier 1 and Tier 2 specialists in Massachusetts. (See pages 107-108 for information about how specialists are tiered.)

If you live outside of Massachusetts, you can see PLUS specialists in your home state for a $60 copay.

Behavioral health providers

Behavioral health providers are providers that treat mental health and substance use disorders. These providers include many types of doctors and therapists, as well as hospitals and other facilities that offer behavioral health treatment.

PLUS behavioral health providers are contracted with Beacon Health Options to provide services to UniCare members. You have lower copays when you use these PLUS behavioral health providers. These providers have gone through a credentialing process and must adhere to the quality standards that UniCare requires.

Important! UniCare's payments to all behavioral health providers are subject to the allowed amount for the claim. PLUS providers accept allowed amounts as payment in full and will not balance bill you. Non-PLUS providers, both in Massachusetts and elsewhere, may balance bill you for charges over the allowed amount (that is, above the amount the Plan paid). See page 27 for information about balance billing protection in Massachusetts.

UniCare will only pay claims from providers who are independently licensed in their specialty area, or are working in a facility or licensed clinic under the supervision of an independently-licensed provider. This is true for both PLUS and non-PLUS behavioral health providers. In Massachusetts, the Department of Public Health (DPH) issues licenses to Massachusetts facilities that provide healthcare services. To be licensed, facilities must meet specific quality and safety standards.

Examples of accepted behavioral health licenses	
▪ MD psychiatrist	▪ BCBA (board-certified behavioral analyst)
▪ PhD	▪ LICSW (licensed social worker)
▪ PsyD (doctorate in psychology)	▪ LMHC (licensed mental health counselor)
▪ EdD (doctorate in education)	▪ LMFT (licensed marriage and family therapist)
	▪ RNCS (registered nurse clinical specialist)

Hospitals and other inpatient facilities

The Plan covers inpatient medical care when you are admitted to an inpatient facility. Your benefits for these services depend on what type of inpatient facility you go to and the type of care you get, as described in Table 19. See pages 60-62 for coverage details.

Table 19. Types of inpatient facilities

Facility	What this type of facility provides
Acute care hospitals	Medical centers and community hospitals that provide treatment for severe illness, conditions caused by disease or trauma, and recovery from surgery. These hospitals deliver intensive, 24-hour medical and nursing care.
Rehabilitation (rehab) facilities	Specialized hospitals that provide rehab services to restore basic functioning (such as walking or sitting upright) that was lost due to illness or injury. Patients in these facilities have a good potential for recovery and are able to participate in a rehab program that includes therapy services for three to five hours a day.
Long-term care facilities	Specialized hospitals that treat patients who need further care for complex medical conditions but that no longer require the services of a traditional hospital. These patients' needs are mostly medical and their ability to participate in rehab is limited.
Skilled nursing facilities	Provide lower intensity rehab and medical services. Patients in these facilities have continuing medical needs that require skilled nursing care, but do not need daily physician care. Some of these patients may or may not require rehab, while others may need long-term custodial care. The Plan does not cover custodial care.

Non-hospital-owned locations

Non-hospital-owned locations are independent, stand-alone facilities that perform outpatient medical services but that aren't owned and operated by a hospital. Facilities that can be either hospital-owned or non-hospital-owned include:

- ❑ Ambulatory surgery centers
- ❑ Walk-in clinics, such as urgent care centers (see "Walk-in clinics", below)
- ❑ Specialized health facilities, such as imaging centers (see "Specialized health facilities" on page 106)

A facility owned by a hospital often bills as the hospital, even if the facility is located somewhere else. This means your claim will be processed as a hospital service, which can result in costs you may not expect.

For example, if you have outpatient surgery at an independent ambulatory surgery center, you won't owe a copay. But if the facility is owned by and bills as a hospital, you'll owe a copay of $110 or $250 depending on the hospital's tier.

Important! A facility's name isn't always a guide to whether it's owned by a hospital. A walk-in clinic that calls itself an urgent care center may bill as a hospital emergency room or a medical practice, instead of as an urgent care center. Before you use a facility, you may want to ask how your visit will be billed. How your visit is billed determines how much you owe.

Find non-hospital-owned facilities in Massachusetts at unicaremass.com

Walk-in clinics

Important! Before you use a walk-in clinic, you may want to find out if your visit will be billed as a hospital service. See “Non-hospital-owned locations”, above, for why this is important.

Walk-in clinics are sites that offer medical care on a walk-in basis, so no appointment is needed. Although walk-in clinics have a variety of different names, they fall into four general categories. These four categories differ based on the services they offer and how they bill for their services.

Table 20. Types of walk-in clinics

Walk-in clinic	What this type of clinic provides
Medical practices	Some doctors’ offices offer services to walk-in patients. They offer the services you’d expect to get at a primary care practice.
Retail health clinics	Located in retail stores or pharmacies. They offer basic services like vaccinations and treatment for colds or mild sinus infections.
Urgent care centers	Independent, freestanding locations that treat conditions that should be handled quickly but that aren’t life-threatening. They often do X-rays, lab tests and stitches.
Hospitals	Some hospitals have walk-in clinics within or associated with their emergency departments.

Telehealth through LiveHealth Online

LiveHealth® Online is a telehealth service that lets you talk face-to-face to a doctor through your smartphone, tablet, or computer with internet access and a camera. You can use this resource to consult with a doctor about common health concerns like colds, the flu, fevers, rashes, infections and allergies. Doctors are available 24 hours a day, 365 days a year.

LiveHealth Online providers are available 24 hours a day, 365 days a year.

Access LiveHealth Online from the Sydney Health app or at livehealthonline.com.

LiveHealth Online is a lower cost option for telehealth provider visits. Your copay when you use LiveHealth Online is always $15. Copays for other telehealth services match the copays for in-person office visits (see page 47).

Preferred vendors

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

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

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

In this handbook, the **checkmark** ✓ identifies services with a preferred vendor benefit.

Find a list of UniCare preferred vendors at unicaremass.com.

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

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.

Specialized health facilities

Specialized health facilities are independent, freestanding centers that provide a variety of medical services. There are four kinds of specialized health facilities:

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

Services at specialized health facilities often cost less than at hospitals, and you may save on your member costs too. You'll have the highest benefit level when you use PLUS specialized health facilities that have agreed to accept UniCare's payment as payment in full.

Be aware, however, that facilities owned and operated by hospitals are hospital sites, not specialized health facilities. The presence of a hospital name indicates that the site is part of a hospital, not an independent facility. See "Non-hospital-owned locations" on page 104 for why this may be important.

Contracted providers

Contracted providers are healthcare providers – such as doctors, hospitals, and health facilities – who have agreed to accept the Plan's payment as payment in full. Contracted providers won't balance bill you for charges over UniCare's allowed amount (that is, the maximum amount that the Plan pays for covered services).

In Massachusetts, you can get care from any medical provider because state law prohibits Massachusetts medical providers from balance billing UniCare members. See page 27 for information about balance billing protection in Massachusetts.

Important! Non-PLUS (non-contracted) behavioral health providers in Massachusetts may balance bill you. Use PLUS (contracted) behavioral health providers to avoid being balance billed.

How to find providers

From the unicaremass.com website, you can look for:

- ❑ Doctors and hospitals, both in Massachusetts and elsewhere
- ❑ Behavioral health providers who are contracted with Beacon Health Options
- ❑ UniCare preferred vendors
- ❑ Other kinds of facilities in Massachusetts, like urgent care centers and ambulatory surgery centers

The Sydney Health app lets you search for medical and behavioral healthcare providers in Massachusetts and elsewhere.

About tiering

Tiering is an important part of the Massachusetts Group Insurance Commission's (GIC) interest in addressing rising healthcare costs. UniCare assigns Massachusetts specialists to levels, or tiers. Similar tiering programs are used in other health plans across the country.

Tiering of medical specialists

Tiering of medical specialists is a part of your benefit plan. You pay lower provider visit copays when you use Massachusetts specialists assigned to Tier 1 and higher copays when you see specialists assigned to other tiers. We understand that our members need to choose specialists who are appropriate for them, and our tiering program does not prevent you from doing so.

About group tiering

UniCare is in the process of moving to group tiering. **Group tiering** means that all specialists within a practice are assigned to the same tier.

UniCare is implementing group tiering over a period of time. For this plan year, specialists are group tiered according to the process described below in "How group tiers are assigned," but hospital tiers (for plans that have hospital tiering) haven't changed. In the future, we will bring the tiering of specialty practices and the hospitals they're related to into closer alignment.

How group tiers are assigned

Each physician group or practice is assigned a tier based on the group's relationship to a hospital. To determine tier placement, UniCare uses the hospital categories developed by the Massachusetts **Center for Health Information and Analysis (CHIA)**. CHIA developed these categories as part of its evaluation of total medical expenses at Massachusetts hospitals. The CHIA categories are:

- ❑ Community
- ❑ Teaching
- ❑ Specialty
- ❑ Academic Medical Center

Table 21 shows how the tiers for specialty practices correspond to the CHIA categories.

Table 21. Definitions of group tiers for specialty practices

Tier definitions	
Tier 1	Practices and specialty groups related to hospitals in CHIA's *Community* categories and large independent physician groups
Tier 2	Practices and specialty groups not in Tier 1 or Tier 3 (including those related to hospitals in CHIA's *Teaching* and *Specialty* categories)
Tier 3	Practices and specialty groups related to hospitals in CHIA's *Academic Medical Center* category

How to find a specialist's tier

When you look for providers from unicaremass.com or Sydney Health, the tier assignments of Massachusetts specialists are indicated on the listing.

Hospital tiering

In the PLUS plan, hospitals are also tiered. There's a complete listing of PLUS hospital tiers in Appendix B. Hospital tier assignments aren't changing this year; however, in the future, hospital tier assignments will also be linked to the CHIA hospital categories.

How UniCare reimburses providers

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

How to submit a claim

To receive benefits from the Plan, a claim must be filed for each service. Most hospitals, doctors and other healthcare providers will submit claims for you. If your provider files claims on your behalf, the provider will be paid directly. If you submit your own claim, you must provide written proof of the claim with the information listed below.

You must provide this information when you submit a claim:

- 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.

Download claim forms and other materials from unicaremass.com.

Claims for prescription drug services – These claims must be submitted directly to the administrator of those services. See Part 4 of this handbook (pages 141-155).

Deadlines for filing claims

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

Checking your claims for billing accuracy

The Bill Checker program

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

What you need to do

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

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

If you find an error

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

How to get your share of the savings

To get your share of the savings, you must send copies of both the original and revised bills to the Plan, along with the completed *Bill Checker* form.

Download the *Bill Checker* form at unicaremass.com. A copy of the form also appears in Appendix C.

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

Provider bills eligible under the program

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

Claim reviews for fraud and other inappropriate activity

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 doctor.

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

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 will be performed at no cost 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 (payment from a third party)

If you or your dependents get 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 get 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.

For additional information about the right of reimbursement, also called subrogation, see page 175.

About your privacy rights

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

About the review process

UniCare reviews certain medical services and inpatient admissions to make sure they are eligible for benefits. See Chapter 3 for information about preapprovals. These **preapproval reviews** – sometimes called **pre-service reviews** or **preauthorizations** – are a standard practice for most health plans. These reviews help ensure that benefits are paid for services that meet the Plan's definition of medical necessity.

> **Note:** 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.

In most cases, your provider will contact UniCare when a service requires review. Callers can leave a message if calling after business hours; Member Services will return the call on the next business day. When calling, UniCare staff will identify themselves by name, title and organization.

Associates, consultants and other providers are not rewarded or offered money or incentives for denying care or a service, or for supporting decisions that result in using fewer services. UniCare doesn't make decisions about hiring, promoting or firing these individuals based on the idea they will deny benefits. Decisions are based only on appropriateness of care and service and existence of coverage.

When preapproval is first requested

When UniCare is notified that you've been admitted to the hospital or are scheduled for a service that needs to be reviewed:

- ❑ Your request goes to a UniCare nurse reviewer, along with any clinical information provided by your doctor or other providers.
- ❑ The nurse reviewer goes over the information to determine if it meets UniCare's medical policies and guidelines and is eligible for benefits.
- ❑ If the nurse reviewer is able to certify that the service is eligible for benefits, the service will be approved.
- ❑ If the nurse reviewer cannot certify the service, he or she will forward your request to a UniCare physician advisor who will determine if the service is eligible for benefits and can be approved.

If the service is approved

When a service is approved, UniCare will notify your doctor and any other providers (such as a hospital) who need to know.

If the service is not approved

When UniCare determines that a service is not eligible for benefits, it's called an **adverse benefit determination**. UniCare will notify you, your doctor and any other providers who need to know. You and your doctor have a couple of options available.

- ❑ **Your doctor can ask UniCare to reconsider** – Your doctor can ask to speak with a physician advisor or submit more supporting information to be reviewed by a physician advisor. A request for reconsideration must occur within three business days of receiving notice of an adverse benefit determination.
- ❑ **You can appeal** – You and your doctor have a legal right to appeal an adverse benefit determination. See Appendix E for instructions on how to file an appeal.

When you need additional approval

Some medical services may be ongoing and need to be reviewed again at a later time. For example, if you are in the hospital, your doctor may recommend that you stay in the hospital beyond the number of days that the Plan first approved. When this happens, UniCare reviews the additional services just as it did when you were first approved.

About your appeal rights

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

Appeals for prescription drug services – These appeals must be filed with the administrator of those services. See Part 4 of this handbook (pages 141-155).

Chapter 9: 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 D, "Mandates and required member notices."

Application for coverage

You must apply to the GIC for enrollment in the Plan. If you have a working email on file with the GIC, you can request the appropriate forms at https://mygiclink.force.com/GenerateDocusignPage. Active employees may contact their GIC Coordinator, and retirees should contact the GIC online or by calling 617-727-2310.

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

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

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

When coverage begins

Coverage under the Plan starts as follows:

For new employees

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

For persons applying during an annual enrollment period

Coverage begins each year on July 1.

For spouses and dependents

Coverage begins on the later of:

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

For surviving spouses

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

When coverage ends for enrollees

Your coverage ends on the earliest of:

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

When coverage ends for dependents

A dependent's coverage ends on the earliest of:

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

Duplicate coverage

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

Special enrollment condition

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

Continuing coverage upon termination of employment

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

Continuing health coverage for survivors

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

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

Coverage will end on the earliest of:

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

Option to continue coverage for dependents age 26 and over

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

Option to continue coverage after a change in marital status

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

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

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

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

Group health continuation coverage under COBRA

This notice explains your COBRA rights 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 healthcare coverage in the GIC's health plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA continuation coverage will begin on the first day of the month immediately after your current GIC coverage ends.

You must complete the GIC COBRA Election Form and return it to the GIC by no later than 60 days after your group coverage ends by sending it by mail to the Public Information Unit at the GIC at P.O. Box 556, Randolph, MA 02368 or by hand delivery to the GIC, 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 continuation 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 continuation 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 continuation coverage.

Who is eligible for COBRA continuation 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 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 continuation 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 continuation 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 continuation coverage last?

By law, COBRA continuation 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 continuation coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA continuation coverage for up to 36 months.

If you have COBRA continuation coverage due to employment termination or reduction in hours, your family members' COBRA continuation 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 continuation 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 continuation 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 continuation 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.** For more information on extending the length of COBRA continuation coverage, visit https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf

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

How and when do I elect COBRA continuation coverage?

Qualified beneficiaries must elect COBRA continuation 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 continuation coverage within the 60-day election period, you will lose all rights to COBRA coverage.**

In considering whether to elect COBRA 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) within 30 days after your GIC coverage ends due to a qualifying event. You will also have the same special enrollment right at the end of COBRA continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA continuation 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 continuation coverage?

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

Your first payment must cover the cost of COBRA continuation 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 continuation 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 continuation 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 continuation 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, if you are a Massachusetts resident, you may purchase health insurance through the Commonwealth's Health Connector Authority, or for employees in other states, through a Health Insurance Marketplace where available. The GIC has no involvement in conversion programs, and only very limited involvement in 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 continuation coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

Additionally, you or other qualified beneficiaries may qualify for MassHealth (Medicaid), Medicare, or the Children's Health Insurance Program (CHIP) or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Important information regarding Medicare and COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- ❑ The month after your employment ends; or
- ❑ The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA continuation coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA continuation coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

Your COBRA continuation 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 continuation coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA continuation coverage.
- ❑ **You must make the first payment for COBRA continuation 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 continuation coverage rights.

- ❑ **You must pay the subsequent monthly cost for COBRA continuation 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 continuation 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 continuation 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 Group Insurance Commission, P.O. Box 556, Randolph, MA 02368.***

If you have questions about COBRA continuation coverage, contact the GIC's Public Information Unit at 617-727-2310, or write to the Unit at P.O. Box 556, Randolph, MA 02368. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.dol/gov/ebsa** or call their toll-free number at 866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit **www.healthcare.gov** or, in Massachusetts visit, **www.mahealthconnector.org**.

Conversion to non-group health coverage

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

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

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

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

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

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

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

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

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

Coordinating benefits with other health plans (COB)

It is common for family members to be covered by more than one healthcare 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 healthcare expenses.

Definition of plan

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

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

Determining the order of coverage

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

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

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

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

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

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

1. The plan without a COB provision is primary.
2. The plan that covers the person as an employee, member, or retiree (that is, other than as a dependent) is primary, and the plan that covers the person as a dependent is secondary.
3. The order of coverage for a dependent child who is covered under both parents' plans is determined by the **birthday rule**, as follows:
   a) The primary plan is the plan of the parent whose birthday falls first in the calendar year, or
   b) If both parents have the same birthday (month and day only), the primary plan is the plan that has covered a parent for the longest period of time

   However, if the other plan has a rule based on the gender of the parent, and if the plans do not agree on the order of coverage, the rules of the other plan will determine the order.
4. The order of coverage for dependent children who are covered under more than one plan, and whose parents are divorced or separated, follows any applicable court decree.

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

   a) First, the plan covering the parent with custody of the child (the custodial parent)
   b) Second, the plan covering the custodial parent's spouse, if applicable
   c) Third, the plan covering the non-custodial parent
   d) Fourth, the plan covering the non-custodial parent's spouse, if applicable
5. According to the **active before retiree rule**, the plan that covers a person as an active employee is primary, and the plan that covers that same person as a retiree is secondary. This applies both to that person and his or her dependents.

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

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

Right to receive and release information

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

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

Facility of payment

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

Right of recovery

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

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

COB for persons enrolled in Medicare

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

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

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

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

Medical coverage primary to Medicare coverage for the disabled

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

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

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

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

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

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

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

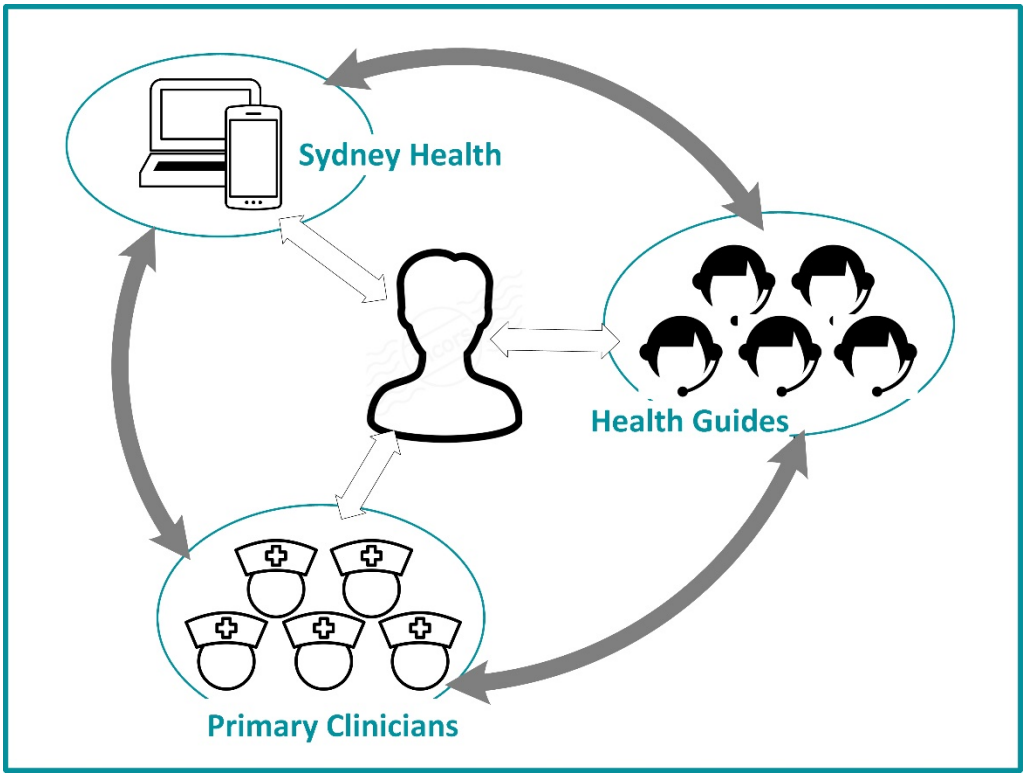
Group Insurance Commission
P.O. Box 556
Randolph, MA 02368

Chapter 10: Other plan resources

The Whole Health, Whole You program

UniCare's **Whole Health, Whole You** program combines healthcare professionals and supporting technology that work together to offer you more personal service and an improved member experience. Whole Health, Whole You integrates these three components:

- **Health guides** (page 126) are specially trained representatives who take members' calls and answer questions.
- **Primary clinicians** (pages 126-127) work one-on-one with members and their families to address personal healthcare goals and issues, like chronic health conditions and healthy living goals.
- **Sydney Health** (page 127) gives you electronic access to plan information and UniCare Member Services from your mobile device.



Because the different components of Whole Health, Whole You can quickly and easily share information with you and with each other, they can provide more personal and thorough responses to your questions and concerns.

UniCare Health Guides: When you call

UniCare health guides answer calls from members. These specially trained service representatives can answer questions and help in a number of other ways.

Health guides can help you…

- Get answers to questions about your plan benefits or claims
- Find out if a service is covered
- Learn more about how your UniCare coverage works
- Find out if you're due for services, like a follow-up appointment or preventive test
- Find providers
- Schedule appointments
- Learn how to compare costs so you can find a cost-effective provider
- Connect with benefits and programs that fit your health needs, like cancer and behavioral health support

How to reach a health guide

	Contact	Hours (Eastern time)
By phone	833-663-4176 / TTY: 711 (toll free)	8:00 a.m. to 8:00 p.m. (M-F)
Send an email	contact.us@anthem.com	Anytime

UniCare Clinical Team: When you need support

UniCare's clinical team consists of healthcare professionals working together to support the health of UniCare members. A primary clinician is your point of contact who works with you directly and, when appropriate, connects you with other specialized professionals on the team.

Primary clinicians work one-on-one with members and their families to address healthcare related issues. Once you connect with your primary clinician, he or she will continue to be the personal health consultant for you and your family – someone you can contact directly. Your primary clinician may also reach out to bring health issues to your attention, or to offer assistance should a health concern arise.

Your primary clinician can help you…

- Get answers to questions about you and your family's healthcare needs
- Determine how to best use your benefits
- Get advice from other professionals on the clinical team, such as health coaches, dieticians, and pharmacists
- Find out how to access other medical and wellness services
- Set and reach your own health goals – like losing weight or quitting smoking
- Arrange care if you need surgery or a medical procedure

Complex health issues almost always require many different types of expertise. This is true whether you are dealing with an ongoing condition like diabetes, or an urgent situation that arises unexpectedly, like a stroke or cancer diagnosis.

For this reason, UniCare's clinical team includes healthcare professionals with expertise in a variety of areas. Working as a team, they can support you and your family, and assist you in effectively managing your healthcare needs.

When you face a complex health issue, the clinical team can help you…

- Understand your diagnosis and treatment options
- Coordinate services where many providers are involved
- Coordinate services before, during, and after a hospital stay
- Facilitate family discussions about healthcare planning
- Work with your doctors to support your present and future healthcare needs
- Work with behavioral health providers to coordinate care and benefits, if you need both medical and behavioral health services
- Find out about education, wellness, self-help and prevention programs to help manage chronic conditions
- Set up a care plan to help ease the shift from hospital to home
- Explore other funding and resources if you have ongoing needs but Plan benefits are limited

Sydney Health: Access from your smartphone

The **Sydney Health** app gives you electronic access to plan information and member services from your mobile device. Download Sydney Health to your mobile device from the App Store® or Google Play®. Once you've registered as a UniCare member, Sydney Health has tools that help you track not just your claims but your overall health and medical situation.

Use the Sydney Health app to…

- Get information about your plan benefits
- Check on the status of your claims
- Look for doctors, hospitals and other health providers
- Keep track of your member costs
- See a doctor face-to-face online with LiveHealth Online
- Get suggestions and tips for managing health conditions like diabetes or asthma
- Sync with a FitBit or other fitness tracker
- Get your electronic member ID card
- Get digital reminders about scheduling checkups and important tests

In this handbook, the **smartphone** symbol lets you know about information you can find, tasks you can perform, and resources that are available through the Sydney Health app.

Behavioral health support services

Behavioral health case management

Behavioral health case management is a program to help you or a family member with your mental health or substance use needs. The goal of the program is to help you be your best, and get the most out of treatment. The program is free for UniCare members, and you don't have to join if you don't want to.

What case managers do…

- Help organize care among your doctors, nurses, and social workers
- Give you information about mental health and substance use services and other community services
- Help you in getting the mental health and substance use services that work best for you
- Help you to follow the instructions from your doctor, nurse, or social worker
- Work with you to get help from local programs
- Help you with a plan to remember to take your medication
- With your permission, keep your primary care provider and psychiatrist updated on your progress

Case management can help if you…

- Have been in the hospital for mental health or substance use reasons
- Have trouble getting the care that works best for you
- Have mental health or substance use issues and also have medical issues
- Need support to help you follow your doctor, nurse, or social worker's advise
- Are pregnant or recently were pregnant and needed mental health or substance use services

Behavioral health case managers are experienced and licensed nurses, social workers, and mental health experts. To find out more about behavioral healthcare management, call UniCare Member Services and ask to speak with a primary clinician.

Behavioral health quality programs

UniCare and Beacon Health Options work together to keep improving the quality of care and services provided for you. We want to ensure that every UniCare member receives safe, effective and responsive treatments to address their healthcare needs. We strive to:

- ❑ Ensure you receive timely service from us and our providers, and that you are satisfied.
- ❑ Ensure that our services are easy to access and meet your cultural needs.
- ❑ Improve any deficits in the services you receive.

You can find more information about Beacon's quality programs at www.beaconhealthoptions.com.

About unicaremass.com

You can find additional information and resources at the unicaremass.com website. At the website, you can:

- ❑ **Check on your claims and other account information** – You'll need to register as a UniCare member (if you haven't already registered through the Sydney Health app). Once you're registered, you can check your account anytime.

  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.

- ❑ **Download forms, fliers, and other materials, including this handbook** – We recommend using your handbook as a PDF because it is almost always easier and faster to find information by searching in a PDF.
- ❑ **Look for healthcare providers such as:**
  - Doctors and hospitals, both in Massachusetts and elsewhere
  - PCPs participating in the Enhanced Personal Health Care program
  - Behavioral health providers who are contracted with Beacon Health Options
  - UniCare preferred vendors
  - Other kinds of facilities in Massachusetts, like urgent care centers and ambulatory surgery centers

In this handbook, the **computer** symbol lets you know about information you can find, tasks you can perform, and resources that are available through unicaremass.com.

Comparing costs at Massachusetts facilities

Different medical facilities can charge different prices for the exact same test or procedure. UniCare's transparency tool lets you compare your costs for common procedures at Massachusetts hospitals and other facilities.

Look for *Compare Costs and Save* at unicaremass.com.

Calling the 24-Hour Nurse Line

The **24-Hour Nurse Line** provides toll-free access to extensive health information at any time. The Nurse Line 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-Hour Nurse Line, 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 Nurse Line can also refer you to local, state and national self-help agencies.

To speak with a nurse, call the Nurse Line toll free at 800-424-8814 and, when prompted, be sure to choose the Nurse Line option.

How to ask for a claim review

If you have questions about a claim, you can ask UniCare to review the claim. 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 Member Services at 833-663-4176
- ❑ **Email** UniCare Member Services 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 ask to have medical information released

We will release your medical information if we get a written request from you to do so.

If you want your medical information sent to another person or company, you must fill out a *Member Authorization Form* that specifies who may see your information.

Download the *Member Authorization Form* from unicaremass.com.

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

Chapter 11: Plan definitions

Term	What it means…
A	
Acupuncture withdrawal management (detox)	The use of acupuncture to ease the symptoms of drug or alcohol withdrawal.
Acute residential treatment	Short-term, 24-hour programs that provide behavioral health treatment within a protected and structured environment.
Acute residential withdrawal management	Drug or alcohol withdrawal (detox) that is medically monitored, for members at risk of severe withdrawal.
Adverse benefit determination *(Appendix E)*	A determination to deny, reduce or terminate, or fail to provide or make a payment (in whole or in part) for a benefit based on any of the following: ▪ The case does not meet the Plan's requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness ▪ The services were determined to be experimental or investigational ▪ The services were not covered based on any plan exclusion or limitation ▪ The person was not eligible to participate in the Plan ▪ The imposition of source of injury exclusion, network exclusion, or other limitation of an otherwise covered benefit ▪ Any instance where the Plan pays less than the total amount of expenses submitted with regard to a claim, including deductible, coinsurance and copays ▪ A rescission of coverage (a retroactive cancellation), except if it results from failure to pay premiums
Allowed amount *(page 27)*	The maximum amount the Plan pays for a covered healthcare service. The allowed amount is the amount UniCare determines to be within the range of payments most often made to similar providers for the same service. The Plan has established allowed amounts for most services from providers. If a non-Massachusetts provider charges more than the allowed amount, you may have to pay the difference. (Also see **Balance billing**.)
Ambulatory surgery center	An independent, freestanding facility licensed to provide same-day 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.
Ambulatory withdrawal management	Drug or alcohol withdrawal process in which a member has daily visits with a provider throughout withdrawal. More commonly called **outpatient detox**.
Appeal *(Appendix E)*	A request that UniCare review an adverse benefit determination or a grievance.
Applied Behavior Analysis (ABA)	Specialized therapy used to treat autism spectrum disorders that focuses on improving appropriate behaviors and minimizing negative behaviors.

Term	What it means…
B	
Balance billing *(page 27)*	When a provider bills you for the difference between what the provider billed 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.
Behavioral health services *(Chapter 5)*	Services to treat mental health and substance use disorder conditions.
C	
Calendar quarter	The four calendar quarters of the year are: ▪ July/August/September ▪ October/November/December ▪ January/February/March ▪ April/May/June
Clinical stabilization services (CSS)	Clinically managed detox and recovery services provided in a non-medical setting.
Coinsurance *(page 25)*	Your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance *plus* any copays and deductibles that may apply.
Community-based acute treatment (CBAT)	Treatment for children and adolescents with serious behavioral health disorders who need a protected and structured environment.
Community support programs (CSP)	Programs to help members access and use behavioral health services.
Contracted provider	Any healthcare provider – such as a doctor, hospital or facility – that has agreed to accept the Plan's payment as payment in full. Contracted providers have gone through a credentialing process and must adhere to the quality standards that UniCare requires.
Copay (copayment) *(pages 21-25)*	A fixed amount you pay for a covered healthcare service, usually when you get the service. The dollar amount of the copay depends on the service it applies to. Not all services have copays.
Cosmetic services *(page 92)*	Services performed mainly to improve appearance. These services do not restore bodily function or correct functional impairment. Cosmetic services are not covered.
Cost sharing *(Chapter 2)*	Your share of the cost for a covered service that you must pay out of your own pocket. Your share can include a copay, coinsurance and/or deductible.
Crisis stabilization unit (CSU)	24-hour observation and supervision for behavioral health conditions when inpatient care isn't needed.
Custodial care *(page 92)*	A level of care that is chiefly designed to assist with activities of daily living and cannot reasonably be expected to greatly restore health or bodily function.

Term	What it means…
D	
Day treatment	Behavioral health programs offering structured, goal-oriented treatment that focuses on improving one's ability to function in the community.
Deductible *(pages 19-21)*	A set dollar amount you pay toward covered services before the Plan starts to pay. For example, if your deductible is $500, the Plan won't pay anything until you've paid that amount toward services that are subject to the deductible. Deductibles don't apply to all services. There are two separate medical deductibles: ▪ PLUS deductible, which applies to PLUS providers and prescription drugs ▪ Non-PLUS deductible, which applies to non-PLUS providers
Dependent *(Chapter 9)*	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.
Dialectical behavioral therapy (DBT)	A combination of behavioral, cognitive and supportive therapies designed to help change unhealthy behaviors and treat people suffering from behavioral health disorders.
DME (durable medical equipment)	Equipment and supplies ordered by a healthcare provider for everyday or extended use. Oxygen equipment, wheelchairs, and crutches are all examples of DME.
DPH-licensed providers	The Massachusetts Department of Public Health (DPH) issues licenses to Massachusetts facilities that provide healthcare services. To be licensed, facilities must meet specific quality and safety standards.
Dual diagnosis acute treatment (DDAT)	Clinically-managed detox and recovery services for those with both a substance use and mental health condition who require a protected and structured environment.
E	
Elective	A medical service or procedure is elective if you can schedule it in advance, choose where to have it done, or both.
Electroconvulsive therapy (ECT)	Psychiatric treatment in which seizures are electrically induced to provide relief from mental disorders.

Term	What it means…
Emergency *(pages 49-51)*	An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: ▪ Your health would be put in serious danger, or ▪ You would have serious problems with your bodily functions, or ▪ You would have serious damage to any part or organ of your body.
Emergency service program (ESP)	Programs that provide behavioral health crisis assessment, intervention and stabilization services on short notice.
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.)
Excluded services *(Chapter 7)*	Healthcare services that the Plan doesn't pay for or cover.
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.
F	
Family stabilization team (FST)	Programs offering intensive services in the home to help children, adolescents and their families deal with complex life stressors.
G	
Grievance	A complaint that you communicate to the Plan.
H	
Healthcare provider	A person, place, or organization that delivers healthcare services or supplies. A provider can be a **person** (like a doctor), a **place** (like a hospital), or an **organization** (like hospice).
Healthcare services	In this handbook, we use "healthcare services" when we're talking about both medical and behavioral health services.
High-tech imaging *(page 56)*	Tests such as MRIs, CT scans and PET scans that give a more comprehensive view of the human body than plain film X-rays. Many of these tests are also much more expensive than traditional X-rays.
Home state	The state where you live and get your routine health care.

Term	What it means…
Hospital / acute care hospital *(pages 60-62)*	A medical center or community hospital that provides treatment for severe illness, conditions caused by disease or trauma, and recovery from surgery. Acute care hospitals deliver intensive, 24-hour medical and nursing care and meet all of the following conditions: ▪ Operate pursuant to law for the provision of medical care ▪ Provide continuous 24-hour-a-day nursing care ▪ Have facilities for diagnosis and major surgery ▪ Provide acute medical/surgical care or acute rehabilitation care ▪ Are licensed as an acute hospital ▪ Have an average length of stay of less than 25 days
I	
Injury	Accidental bodily harm caused by something external (outside of your body).
Inpatient behavioral health services *(pages 79-80)*	Treatment for behavioral health conditions that have severe symptoms but that are expected to improve with intensive, short-term treatment.
Inpatient medical care *(pages 60-62)*	Medical care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Inpatient hospital services may also be referred to as **hospitalization**.
Intensive outpatient program (IOP)	Programs that offer thorough, regularly-scheduled behavioral health treatment in a structured environment. These programs offer at least three hours of therapy a day, up to seven days a week.
L	
Long-term care facilities *(pages 60-62)*	Specialized hospitals that treat patients who need further care for complex medical conditions but no longer require the services of a traditional hospital.
M	
Maintenance care	A treatment plan or therapy performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the nature of the treatment becomes supportive rather than corrective.
Medical services	In this handbook, medical services are services to treat medical (physical) conditions – in contrast to **Behavioral health services**.
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.

Term	What it means…
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.
Medication-assisted treatment (MAT) *(page 80)*	Long-term prescribing of medication as an alternative to the opioid on which a member was dependent. Typically, a member goes to a clinic daily to get the medication.
Medication management	Visits with a behavioral health provider who can evaluate and prescribe medication, if needed.
Member	An enrollee or his/her dependent who is covered by the Plan.
Member costs *(Chapter 2)*	Costs that you pay yourself toward your medical bills: deductible, copays and coinsurance. Member costs are also known as **out-of-pocket costs**.
N	
Neuropsychological (neuropsych) testing	Testing to find out if a problem with the brain is affecting one's ability to reason, concentrate, solve problems, or remember.
Non-hospital-owned location *(page 104)*	Facilities that perform outpatient medical services but that are not owned by or operated by a hospital. Non-hospital-owned locations include many ambulatory surgery centers, urgent care centers and doctor's offices.
Non-preferred vendor *(page 105)*	A vendor who does not have a contract with the Plan to provide certain services or equipment including, but not limited to, durable medical equipment and medical supplies. You pay more member costs when you use non-preferred vendors.

Term	What it means…
O	
Observation care	A well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made about whether a patient will need inpatient hospital treatment or if he or she can be discharged from the hospital. Observation care is considered outpatient and is usually provided in medical centers and community hospitals.
Office services *(pages 81-82)*	Behavioral health services that can be provided in an office or office-like setting
Opiate treatment programs (OTP)	Programs licensed to distribute and administer medications as an alternative to an opioid on which a member was dependent.
Out-of-pocket costs	See **Member costs**
Out-of-pocket (OOP) maximum *(pages 25-26)*	A limit on the member costs (deductible, copays, coinsurance) you have to pay for covered services. Once you reach a limit, the Plan then pays 100% of the allowed amounts for the rest of the plan year. There are two separate out-of-pocket maximums, each of which applies to different services: ▪ **PLUS OOP maximum** – Limits your member costs for services with PLUS providers and for prescription drugs ▪ **Non-PLUS OOP maximum** – Limits your member costs for services with non-PLUS providers Neither of these limits include premiums, balance-billed charges, or costs for services that the Plan doesn't cover.
Outpatient behavioral health services *(pages 82-83)*	Services that don't require an inpatient hospital admission or overnight stay but that do require more intensive support than other kinds of behavioral health care.
Outpatient hospital services	Care at a hospital that doesn't require being admitted to the hospital. Outpatient care usually doesn't include an overnight stay. **Outpatient services** sometimes means health care provided at any non-hospital facility, such as a doctor's office or walk-in clinic.
P	
Palliative care	Medical care that focuses on treating symptoms – like severe pain, or difficulty breathing – to make you more comfortable. Palliative care is not intended to cure underlying conditions.
Partial hospitalization programs (PHP)	Non-residential, structured outpatient psychiatric and substance use programs that are more intensive than one would get in a doctor's office, but that are an alternative to inpatient care. These programs offer at least five hours of therapy a day, up to seven days a week.

Term	What it means…
Physician	Includes the following healthcare providers acting within the scope of their licenses or certifications: ▪ Certified nurse midwife ▪ Chiropractor ▪ Dentist ▪ Nurse practitioner ▪ Optometrist ▪ Physician ▪ Physician assistant ▪ Podiatrist See page 103 for a list of types of behavioral health providers.
Plan year	The plan year starts on July 1 each year and ends the following June 30th.
PLUS provider	PLUS providers are all physicians and hospitals in Massachusetts. PLUS providers also include: ▪ Ambulatory surgery centers in Massachusetts ▪ Preferred vendors ▪ Contracted specialized health facilities in Massachusetts ▪ Contracted providers outside of Massachusetts
Preapproval *(Chapter 3)*	Review process to confirm that a service you're going to have is eligible for benefits. Preapproval review lets you make sure that services you'll be getting are covered under the Plan.
Preferred vendors *(page 105)*	Providers that the Plan contracts with to provide certain services or equipment including, but not limited to, durable medical equipment (DME), medical supplies, and home health care. You get these services at a higher benefit level when you use preferred vendors.
Provider	See **Health care provider**
Psychiatric visiting nurse (VNA) services	Short-term treatment delivered in the home or living environment to treat a behavioral health disorder with medication.
Psychological (psych) testing	Standardized assessment tools to diagnose and assess overall psychological functioning.
R	
Rehabilitation (rehab) facilities *(pages 60-62)*	Specialized hospitals that provide rehab services to restore basic functioning (such as walking or sitting upright) that was lost due to illness or injury.
Rehabilitation (rehab) services	Healthcare 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.

Term	What it means…
Respite care	Services given to an ill patient to relieve the family or primary care person from caregiving functions.
Retail health clinic *(page 105)*	Walk-in clinics located in retail stores or pharmacies. They offer basic services like vaccinations and treatment for colds or mild sinus infections.
S	
Skilled care	Medical services that can only be provided by a registered or certified professional healthcare provider.
Skilled nursing facility *(pages 60-62)*	An institution that provides lower intensity rehab and medical services. Skilled nursing facilities must meet all of the following conditions: ▪ Operates according to law ▪ Is approved as a skilled nursing facility for payment of Medicare benefits, or is qualified to receive such approval, if requested ▪ Is licensed or accredited as a skilled nursing facility (if applicable) ▪ Primarily engages in providing room and board and skilled care under the supervision of a physician ▪ Provides continuous 24-hour-a-day skilled care by or under the supervision of a registered nurse (RN) ▪ Maintains a daily medical record for each patient A facility does not qualify as a skilled nursing facility if it is used primarily for: ▪ Rest ▪ Mental health or substance use disorder treatment ▪ Educational care ▪ Custodial care (such as in a nursing home)
Specialized health facilities *(page 106)*	Independent, freestanding centers that provide a variety of outpatient medical services. The four types of specialized health facilities are: ▪ Dialysis centers ▪ Fertility clinics ▪ Imaging centers ▪ Sleep study centers
Spouse	The legal spouse of the covered employee or retiree.
Structured outpatient addictions programs (SOAP)	Non-residential, structured substance use disorder programs that are more intensive than one would get in a doctor's office, but that are an alternative to inpatient care. These programs offer at least three hours of therapy a day, up to seven days a week.
Substance use disorder assessment / referral *(page 83)*	A comprehensive assessment of substance use to allow a provider to refer a member to appropriate care.

Term	What it means…
T	
Tiers *(page 107-108)*	Different levels that the Plan groups specialists and hospitals into.
Transcranial magnetic stimulation (TMS)	A non-invasive method of brain stimulation used to treat major depression.
Transitional care unit (TCU)	Facilities that help children and adolescents transition from an acute care facility to home, a residential program, or foster care.
U	
Urgent care *(pages 49-51)*	Care 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.
Urgent care center *(page 105)*	An independent, freestanding facility that treats conditions that should be handled quickly but that aren't life-threatening. Urgent care centers often do X-rays, lab tests and stitches.
V	
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.
W	
Walk-in clinics *(page 105)*	Sites that offer medical care on a walk-in basis, so no appointment is needed. Urgent care centers and retail health clinics are two examples of walk-in clinics.

PART 4:

YOUR PRESCRIPTION DRUG BENEFITS

Description of coverage for prescription drugs

For questions about any of the information in Part 4 of this handbook, please call Express Scripts at 855-283-7679.

Administered by

Chapter 12: Your prescription drug plan

GIC's Pharmacy Benefit

The GIC's prescription drug benefits are administered through Express Scripts.

For questions about any of the information in this section, please contact Express Scripts at 855-283-7679.

Express Scripts is the pharmacy benefit manager for your prescription drug benefit plan. The Express Scripts pharmacy network includes major chain pharmacies nationwide, many independent pharmacies, a mail order pharmacy and a specialty drug pharmacy.

If you have any questions about your prescription drug benefits, contact Express Scripts Member Services toll free at 855-283-7679.

About Your Plan

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

The plan categorizes medications into seven major categories:

Generic Drugs

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

Maintenance Drug

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

Non-Preferred Brand-Name Drug

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

Preferred Brand-Name Drug

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

Preventive Drugs

Preventive drugs consist primarily of drugs recommended for coverage by the U.S. Preventive Services Task Force, and as specified by the federal Patient Protection and Affordable Care Act. See “Preventive Drugs” on page 148 for more information.

Specialty Drugs

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

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

Over-the-Counter (OTC) Drugs

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

Copays and Deductible

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

Table 22. Deductible for prescription drugs

Deductible (fiscal year July 1 through June 30)	
For individual coverage	**$100 for one person**
For family coverage	**$200 for the entire family** *No more than $100 per person will be applied to the family deductible. Multiple family members can satisfy the family deductible.*

Table 23. Copays for prescription drugs

Copay for	Participating Retail Pharmacy up to 30-day supply	Mail Order or CVS Pharmacy up to 90-day supply
Tier 1 – Generic Drugs	$10	$25
Tier 2 – Preferred Brand-Name Drugs	$30	$75
Tier 3 – Non-Preferred Brand-Name Drugs	$65	$165
Other ▪ Orally-administered anti-cancer drugs ▪ Generic drugs to treat opioid use disorder (generic buprenorphine-naloxone, naloxone, and naltrexone products) ▪ Preventive drugs: Refer to the "Preventive Drugs" section below for detailed information	$0 member cost (deductible does not apply)	$0 member cost (deductible does not apply)

Copay for	**Specialty drugs must be filled only through Accredo, a specialty pharmacy.**
Specialty Drugs: Tier 1	$10 per 30-day supply
Specialty Drugs: Tier 2	$30 per 30-day supply
Specialty Drugs: Tier 3	$65 per 30-day supply
Orally-administered anti-cancer specialty drugs	$0 per 30-day supply

Specialty medications may be dispensed up to a 30-day supply; some exceptions may apply.

Copay for ADHD medications	**May be filled through mail order or any network pharmacy. Limited to a 60-day supply per state statute.**
Tier 1	$20 per 60-day supply
Tier 2	$60 per 60-day supply
Tier 3	$130 per 60-day supply

Out-of-Pocket Maximum

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

Table 24. Out-of-pocket maximum

Individual	$5,000
Family	$10,000

How to Use the Plan

After you first enroll in the plan, Express Scripts will send you a welcome packet and Express Scripts Prescription Card(s). Your Prescription Card(s) will be mailed to you with ID cards for you and your dependents (if any) along with a mail order form.

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

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

Filling Your Prescription

You may fill your prescriptions for non-specialty drugs at any participating retail pharmacy, or through mail order from the Express Scripts Pharmacy℠. Prescriptions for specialty drugs must be filled as described in the "Accredo, an Express Scripts Specialty Pharmacy" subsection.

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

Short-Term Medications – Up to 30 Days

Filling Your Prescriptions at a Participating Retail Pharmacy

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

You can locate the nearest participating retail pharmacy anytime online after registering at express-scripts.com or by calling toll free at 855-283-7679.

If you do not have your Prescription Card the pharmacist can also verify eligibility by contacting the Express Scripts Pharmacy Help Desk at 800-922-1557; TDD: 800-922-1557.

Maintenance Medications – Up to 30 Days

After you fill two 30-day supplies of a maintenance medication at a retail pharmacy, you will receive a letter from Express Scripts explaining how you may convert your prescription to a 90-day supply to be filled either through mail order or at a CVS Pharmacy.

You will receive coverage for additional fills of that medication only if you convert your prescription to a 90-day supply to be filled either through mail order or at a CVS Pharmacy, or if you inform Express Scripts that you instead prefer to continue to receive 30-day supplies at a participating retail pharmacy. Exceptions for this policy do apply to ADHD medications. Per state statute, prescriptions are limited to a 60-day supply.

Express Scripts will assist you in transitioning your maintenance prescription to either mail order or a CVS Pharmacy location.

Maintenance Medications – Up to 90 Days

Filling 90-day Prescriptions Through the Express Scripts Pharmacy or CVS Pharmacy

You have the choice and convenience of filling maintenance prescriptions for up to a 90-day supply at the mail order copay, either through the Express Scripts Pharmacy or at a CVS Pharmacy.

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

CVS Pharmacy is another option for getting your 90-day maintenance medications for the same copay amount as mail order. Prescriptions can be filled at a CVS Pharmacy locations across the country.

Convenient for You

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

Using Mail Order from the Express Scripts Pharmacy

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

1. Ask your physician to write a prescription for up to a 90-day supply of your maintenance medication plus refills for up to one year, if appropriate. (Remember also to ask for a second prescription for an initial 30-day supply and take it to your local participating retail pharmacy.)
2. Complete a mail order form (contained in your Welcome Kit or found online after registering at express-scripts.com). Or call Express Scripts Member Services toll free at 855-283-7679 to request the form.
3. Put your prescription and completed order form into the return envelope (provided with the order form) and mail it to the Express Scripts Pharmacy.

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

If the Express Scripts Pharmacy is unable to fill a prescription because of a shortage of the medication, you will be notified of the delay in filling the prescription. You may then fill the prescription at a retail pharmacy, but the retail pharmacy copay will apply.

Accredo, an Express Scripts Specialty Pharmacy

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

You will be required to fill your specialty medications at Accredo. This means that your prescriptions can be sent to your home or your doctor's office.

Specialty medications may be filled only at a maximum of a 30-day supply; some exceptions may apply. Many specialty medications are subject to a clinical review by Express Scripts to ensure the medications are being prescribed appropriately.

Accredo offers a complete range of services and specialty drugs. Your specialty drugs are quickly delivered to any approved location, at no additional charge. We ship to all 50 states using one of our preferred expedited carriers. We can also ship to a variety of alternate addresses, including physician's offices or to another family member's address. We do not ship to P.O. boxes.

You have toll-free access to expert clinical staff who are available to answer all of your specialty drug questions. Accredo will provide you with ongoing refill reminders before you run out of your medications.

To begin receiving your specialty drugs through Accredo, call toll free at 855-667-8678.

Accredo Pharmacy Services

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

Claim Forms

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

Table 25. Claims reimbursement

Type of Claim	Reimbursement
Claims for purchases at a participating (in-network) pharmacy without an Express Scripts Prescription Card.	Claims incurred within 30 days of the member's eligibility effective date will be covered at full cost, less the applicable copay. -or- Claims incurred more than 30 days after the member's eligibility effective date will be reimbursed at a discounted cost, less the applicable copay.
Claim forms are available to registered users on express-scripts.com or by calling 855-283-7679.	

Other Plan Provisions

Preventive Drugs

Coverage will be provided for the following drugs:[1]

Preventive Drugs	
Aspirin	Generic OTC aspirin ≤ 325mg when prescribed for adults less than 70 years of age for the prevention of heart attack or stroke and to help prevent illness and death from preeclampsia for females who are at high risk for the condition
Bowel preparation medications	Generic (Rx and OTC) products for adults ages 50 to 75 years old. Limited to 2 prescriptions at $0 copay each year
Contraceptives	Generic and brand versions of contraceptive drugs and devices, and OTC contraceptive products, when prescribed for women less than 50 years old. Per state statute, some oral contraceptives can be dispensed up to a 3-month supply for the first fill and up to a 12-month supply for subsequent fills.
Folic acid supplements	Generic OTC and Rx versions (0.4mg – 0.8mg strengths only) when prescribed for women under the age of 51
HIV Pre-Exposure Prophylaxis (PrEP)	Generic only (Brand Truvada covered only until generic becomes available). No age restriction. No copay.
Immunization vaccines	Generic or brand versions prescribed for children or adults
Oral fluoride supplements	Generic and brand supplements prescribed for children 6 months through 5 years of age for the prevention of dental caries
Breast cancer	Generic prescriptions for raloxifene or tamoxifen are covered for the primary prevention of breast cancer for females who are at increased risk, age 35 years and older
Tobacco cessation	All FDA-approved smoking cessation products prescribed for adults, age 18 and older
Statins	Generic-only, single-entity, low-to-moderate dose statin agents for adults 40 to 75 years old

Call Express Scripts at 855-283-7679 for additional coverage information on specific preventive drugs.

Brand-Name Drugs with Exact Generic Equivalents

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

1 This list is subject to change during the year. Call Express Scripts toll free at 855-283-7679 to check if your drugs are included in the program.

Prescription Drugs with Over-the-Counter (OTC) Equivalents

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

Some prescription drugs also have OTC product alternatives available. These OTC products, though not identical, are very similar to the prescription drugs.

Prior Authorization

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

If a drug that you take requires prior authorization, your physician will need to contact Express Scripts to see if the prescription meets the plan's conditions for coverage. If you are prescribed a drug that requires prior authorization, your physician should call Express Scripts at 800-417-1764.

Table 26. Current examples of drugs requiring prior authorization for specific conditions[1]

Drug Class	Products Requiring Prior Authorization (PA)
Topical Acne Products	Tazorac® 0.05% and 0.1% cream, gel; Fabior 0.1% foam; (Retin-A®, Retin-A® Micro®; Avita®; Tretin·X™; Atralin™ gel; other generic topical tretinoin products) and Clindamycin Phosphate 1.2% and Tretinoin 0.025% gel (Ziana®; Veltin™)
Testosterone – Topical	Androderm, AndroGel, Axiron, Fortesta, Striant, Testim
Testosterone – Injectable	Aveed®, Depo® – Testosterone [testosterone cypionate injection, generics], Delatestryl®, Xyosted® [testosterone enanthate injection, generics], Testopel® [testosterone pellet]
Glaucoma: Ophthalmic Prostaglandin	Lumigan, Xalatan [generics], Travatan, Travatan Z, Zioptan
Compounds – Select Compounds	A compounded medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available.
Diabetes GLP-1 Agonists	Adlyxin, Byetta®, Bydureon®/BCISE, Ozempic, Rybelsus, Tanzeum Trulicity®, Victoza®, Incretin Mimetics
Rosacea	Mirvaso®, Rhofade™ cream

1 This list is not all-inclusive and is subject to change during the year. Call Express Scripts toll free at 855-283-7679 to check if your drugs are included in the program.

Drug Class	Products Requiring Prior Authorization (PA)
Nutritional Supplements	Non-prescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids
Pain	Fentanyl Transmucosal Drugs (Abstral®, Actiq®, Fentora®, Lazanda®, Subsys®) Lidoderm®, Ztildo
Weight Management	Adipex (phentermine), Bontril (phendimetrazine), Contrave (bupropion; naltrexone), Didrex (benzphetamine), Sanorex (mazindol), Suprenza (phentermine), Tenuate (diethylpropion), Xenical (orlistat), Belviq, Qsymia, Saxenda
Dry Eyes	Cequa, Restasis®, Xildra®

Table 27. Current examples of top drug classes that may require prior authorization for medical necessity

- Dermatological Agents
- Diabetic Supplies
- Epinephrine Auto-Injector Systems
- Erectile Dysfunction Oral Agents
- Erythropoiesis-Stimulating Agents
- Glaucoma
- Growth Hormones
- Hepatitis C Agents
- Insulins
- Nasal Steroids
- Ophthalmic Agents
- Opioid Analgesics
- Opioid Dependence Agents
- Osteoarthritis – Hyaluronic Acid Derivatives
- Osteoporosis Therapy
- Proton Pump Inhibitors

Select drugs within these classes require prior authorization for medical necessity to ensure formulary alternative(s) within the class have been tried. If you are a registered user on express-scripts.com, refer to the National Preferred Formulary or call Express Scripts toll free at 855-283-7679 for additional information.

Quantity Dispensing Limits

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

Quantity per dispensing limits are based on the following:

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

Examples of drugs with quantity limits currently include Cialis®, Imitrex®, and lidocaine ointment.

Drug Utilization Review Program

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

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

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

Exclusions

Benefits exclude:[1]

- Dental preparations (e.g., topical fluoride, Arestin®), with the exception of oral fluoride
- Over-the-counter drugs, vitamins or minerals (with the exception of diabetic supplies and preventive drugs)
- Homeopathic drugs
- Prescription products for cosmetic purposes such as photo-aged skin products and skin depigmentation products
- Medications in unit dose packaging
- Impotence medications for members under the age of 18
- Injectable allergens
- Hair growth agents
- Special medical formulas and medical food products, except as required by state law
- Compounded medications – some exclusions apply. Examples include bulk powders, bulk chemicals, and proprietary bases used in compounded medications
- Drugs administered intrathecally, by or under the direction of healthcare professionals and recommended to be administered under sedation

Definitions

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

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

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

1 This list is subject to change during the year. Call Express Scripts toll free at 855-283-7679 to check if your drugs are included in the program.

Deductible – A deductible is the dollar amount you must pay during a plan year before the copays for covered prescriptions apply.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Member Appeals

Express Scripts has processes to address:

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

All appeals should be sent to Express Scripts at the following address:

Complete the form and fax it to 877-328-9660 or mail to:

Express Scripts
Attn: Benefit Coverage Review Department
P.O. Box 66587
St Louis, MO 63166-6587

All calls should be directed to Express Scripts Member Services at 855-283-7679.

To request an initial administrative coverage review, the member or his or her representative must submit the request in writing using a Benefit Coverage Request Form, which can be obtained by calling the Member Services phone number on the back of the prescription card.

Internal Inquiry

Call Express Scripts Member Services to discuss concerns you may have regarding your prescription drug coverage. Every effort will be made to resolve your concerns. If your concerns cannot be resolved or if you tell a Member Services representative you are not satisfied with the response you have received, Member Services will notify you of any options you may have, including the right to have your inquiry processed as an appeal. Member Services will also provide you with the steps you and your doctor must follow to submit an appeal.

Internal Member Appeals

Requests for coverage that were denied as specifically excluded in this member handbook or for coverage that was denied based on medical necessity determinations are reviewed as appeals through the Express Scripts Internal Appeals Process. You may file an appeal request yourself or you may designate someone to act on your behalf in writing. You have 180 days from the date you were notified of the denial of benefit coverage or prescription drug claim payment to file your appeal. To request an initial administrative coverage review, the member or his or her representative must submit the request in writing using a Benefit Coverage Request Form, which can be obtained by calling the Customer Service phone number on the back of the prescription card.

1. You must submit a written appeal to the address listed above. Your letter should include:
   - ❑ Your complete name and address;
   - ❑ Your Express Scripts ID number;
   - ❑ Your date of birth;
   - ❑ A detailed description of your concern, including the drug name(s) being requested; and
   - ❑ Copies of any supporting documentation, records or other information relating to the request for appeal
2. The Express Scripts Appeals Department will review appeals concerning specific prescription drug benefit provisions, plan rules, and exclusions and make determinations. If you are not satisfied with an Appeals Department denial related to a plan rule or exclusion (i.e., non-medical necessity appeal), you may have the right to request an independent External Review of the decision (refer to the “External Review Appeals” section for details on this process).

   For denials related to a medical necessity determination, you have the right to an additional review by Express Scripts. Express Scripts will request this review from an independent practitioner in the same or in a similar specialty that typically manages the medical condition for which the prescription drug has been prescribed. If the second review is an adverse determination, you have the right to request an External Review of this decision (refer to the “External Review Appeals” section for details on this process).
3. For an appeal on a prescription drug that has not been dispensed, an Appeals Analyst will notify you in writing of the decision within no more than fifteen calendar days of the receipt of an appeal. For an appeal on a prescription drug already dispensed, an Appeals Analyst will notify you in writing of the decision within no more than thirty calendar days of the receipt of an appeal.

   A copy of the decision letter will be sent to you and your physician. A determination of denial will set forth:
   - ❑ Express Scripts’ understanding of the request;
   - ❑ The reason(s) for the denial;
   - ❑ Reference to the contract provisions on which the denial is based; and
   - ❑ A clinical rationale for the denial, if the appeal involves a medical necessity determination.

Express Scripts maintains records of each inquiry made by a member or by that member’s designated representative.

Express Scripts recognizes that there are circumstances that require a quicker turnaround than allotted for the standard Appeals Process. Express Scripts will expedite an appeal when a delay in treatment would seriously jeopardize your life and health or jeopardize your ability to regain maximum function. If your request does not meet the guidelines for an expedited appeal, Express Scripts will explain your right to use the standard appeals process.

If your request meets the guidelines for an expedited appeal, it will be reviewed by a practitioner in the same or in a similar specialty that typically manages the medical condition for which the prescription drug has been prescribed. Express Scripts will notify you of its decision by telephone no later than 72 hours after Express Scripts' receipt of the request.

If the patient or provider believes the patient's situation is urgent, the provider must request the expedited review by phone at 800-753-2851.

External Review Appeals

In most cases, if you do not agree with the Appeals decision, you or your authorized representative have the right to request an independent, external review of the decision. Should you choose to do so, send your request within four months of your receipt of the written notice of the denial of your appeal to:

To submit an external review, the request must be mailed or faxed to MCMC, LLC, an independent third party utilization management company, at:

MCMC LLC
Attn: Express Scripts Appeal Program 300 Crown Colony Drive, Suite 203
Quincy, MA 02169-0929
617-375-7700, ext. 28253
617-375-7683

In some cases, members may have the right to an expedited external review. An expedited external review may be appropriate in urgent situations. Generally, an urgent situation is one in which your health may be in serious jeopardy, or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. The request must be received within 4 months of the date of the final internal adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day. For urgent external appeals urgent external review, the IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

If you request an external review, an independent organization will review the decision and provide you with a written determination. If this organization decides to overturn the Appeals decision, the service or supply will be covered under the plan.

If you have questions or need help submitting an appeal, please call Customer Care for assistance at 855-283-7679.

Health and Prescription Information

GIC authorizes health and prescription information about members be used by Express Scripts to administer benefits. As part of the administration, Express Scripts may report health and prescription information to the administrator or sponsor of the benefit plan. Express Scripts also uses that information and prescription data gathered from claims nationwide for reporting and analysis without identifying individual members.

PART 5:

APPENDICES

Notices and reference information

Appendix A: GIC notices

Notice of Group Insurance Commission (GIC) Privacy Practices

Effective September 3, 2013

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at www.mass.gov/GIC.

Required and permitted uses and disclosures

We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make *without* your authorization:

Payment activities

The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying healthcare claims, and determining eligibility for health benefits.

Healthcare operations

The GIC may use and share PHI to operate its programs that include evaluating the quality of healthcare services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce healthcare costs and improve plan performance.

To provide you information on health-related programs or products

Such information may include alternative medical treatments or programs or about health-related products and services, subject to limits imposed by law as of September 23, 2013.

Other permitted uses and disclosures

The GIC may use and share PHI as follows:

- ❑ To resolve complaints or inquiries made by you or on your behalf (such as appeals);
- ❑ To enable business associates that perform functions on our behalf or provide services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. Our business associates are also directly subject to federal privacy laws;
- ❑ For data breach notification purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access or disclosure of your health information;
- ❑ To verify agency and plan performance (such as audits);
- ❑ To communicate with you about your GIC-sponsored benefits (such as your annual benefits statement);
- ❑ For judicial and administrative proceedings (such as in response to a court order);
- ❑ For research studies that meet all privacy requirements; and
- ❑ To tell you about new or changed benefits and services or healthcare choices.

Required disclosures

The GIC **must** use and share your PHI when requested by you or someone who has the legal right to make such a request on your behalf (your Personal representative), when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations that assist us

In connection with payment and healthcare operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI and also have direct responsibility to protect your PHI imposed by federal law.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your rights

You have the right to:

- ❑ Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- ❑ Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this by in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.

- ❑ Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your healthcare treatment, payment or operations; or (5) part of a limited data set for research;
- ❑ Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and healthcare operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- ❑ Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
- ❑ Receive notification of any breach of your unsecured PHI.
- ❑ Receive a separate paper copy of this notice upon request. (An electronic version of this notice is on our website at www.mass.gov/GIC.)

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 556, Randolph, MA 02368. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call 617-727-2310, extension 1 or TTY for the deaf and hard of hearing at 617-227-8583.

Important notice from the GIC about your prescription drug coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with UniCare State Indemnity Plan/PLUS and your options under Medicare's prescription drug coverage. This information can help you decide whether or not to join a non-GIC Medicare drug plan. If you are considering joining a non-GIC plan, you should compare your current coverage – particularly which drugs are covered, and at what cost – with that of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage can be found at the end of this notice.

For most people, the drug coverage that you currently have through your GIC health plan is a better value than the Medicare drug plans.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available to everyone with Medicare in 2006. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The GIC has determined that the prescription drug coverage offered by your plan is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Part D drug plan.

When can you join a Medicare Part D drug plan?

You can join a non-GIC Medicare drug plan when you first become eligible for Medicare and each subsequent year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two month Special Enrollment Period to join a non-GIC Medicare drug plan.

What happens to your current coverage if you decide to join a non-GIC Medicare drug plan?

- ❑ If you enroll in another Medicare prescription drug plan or a Medicare Advantage plan with or without prescription drug coverage, you will be disenrolled from the GIC-sponsored CVS Caremark plan. If you are disenrolled from CVS Caremark, you will lose your GIC medical, prescription drug, and behavioral health coverage.
- ❑ If you are the insured and decide to join a non-GIC Medicare drug plan, both you and your covered spouse/dependents will lose your GIC medical, prescription drug, and behavioral health coverage.
- ❑ If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available online at **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 **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 **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 **https://www.dol.gov/agencies/vets/programs/userra**. An interactive online USERRA Advisor can be viewed at **https://webapps.dol.gov/elaws/vets/userra/**. 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: Tier designations for Massachusetts hospitals

As a PLUS member, you can use any Massachusetts hospital, which are designated by their tier (Tier 1, 2 or 3). PLUS members who live elsewhere in New England can use contracted hospitals in their state at the $500 inpatient hospital quarterly copay.

From the unicaremass.com website, you can look for hospitals both in Massachusetts and elsewhere.

PLUS Tier 1 hospitals

- Addison Gilbert Hospital (Northeast)
- Anna Jaques Hospital
- Athol Hospital
- Baystate Franklin Medical Center
- Baystate Medical Center
- Berkshire Medical Center
- Beverly Hospital (Northeast)
- Brockton Hospital (Signature Healthcare)
- Cambridge Hospital (Cambridge Health Alliance)
- Cape Cod Hospital
- Carney Hospital
- Charlton Memorial Hospital (Southcoast)
- Cooley Dickinson Hospital
- Emerson Hospital
- Everett Hospital – Whidden (Cambridge Health Alliance)
- Fairview Hospital
- Framingham Union Hospital (MetroWest)
- Good Samaritan Medical Center
- Harrington Memorial Hospital
- Heywood Hospital
- Holy Family Hospital – Methuen
- Holyoke Medical Center
- Lawrence General Hospital
- Lawrence Memorial Hospital of Medford
- Leonard Morse Hospital
- Lowell General Hospital
- Melrose-Wakefield Hospital
- Mercy Medical Center
- Merrimack Valley Hospital (Holy Family)
- Milford Regional Medical Center
- Morton Hospital
- Mount Auburn Hospital
- Nashoba Valley Medical Center
- Noble Hospital (Baystate)
- Norwood Hospital
- Saint Vincent Hospital
- Saints Medical Center (Lowell General)
- South Shore Hospital
- St. Anne's Hospital
- St. Elizabeth's Medical Center
- St Luke's Hospital (Southcoast)
- Sturdy Memorial Hospital
- Tobey Hospital (Southcoast)
- Winchester Hospital
- Wing Hospital (Baystate)

PLUS Tier 2 hospitals

- Beth Israel Deaconess Medical Center – Boston
- Boston Children's Hospital
- Burbank Hospital (HealthAlliance)
- Clinton Hospital (HealthAlliance)
- Dana-Farber Cancer Institute
- Falmouth Hospital
- Leominster Hospital (HealthAlliance)
- Marlborough Hospital (UMass Memorial)
- Martha's Vineyard Hospital
- Massachusetts Eye and Ear
- Milton Hospital (Beth Israel Deaconess)
- Nantucket Cottage Hospital
- Needham Hospital (Beth Israel Deaconess)
- New England Baptist Hospital
- Plymouth Hospital (Beth Israel Deaconess)
- Shriner's Hospital for Children – Boston
- Shriner's Hospital for Children – Springfield
- UMass Memorial Medical Center

PLUS Tier 3 hospitals

- Boston Medical Center
- Brigham and Women's Hospital
- Faulkner Hospital (Brigham and Women's)
- Floating Hospital for Children at Tufts Medical Center
- Lahey Hospital & Medical Center – Burlington
- Lahey Medical Center – Peabody
- Massachusetts General Hospital
- MassGeneral for Children at North Shore Medical Center
- Newton-Wellesley Hospital
- North Shore Medical Center
- Salem Hospital (North Shore Medical Center)
- Tufts Medical Center

Appendix C: Forms

This appendix contains the following forms:

- ❑ Bill Checker Program Form
- ❑ Diabetes Prevention Program Reimbursement Form
- ❑ Fitness Reimbursement Form

Download these forms and other materials from unicaremass.com. You can also request materials from UniCare Member Services at 833-663-4176.

Bill Checker Program Form

See "Checking your claims for billing accuracy" on page 109 for details about the Bill Checker program.

What is the Bill Checker program?

UniCare's Bill Checker program gives you the opportunity to **share in any savings** that result if you find errors on your medical bills.

UniCare encourages you to always **review your medical bills for accuracy**. If you do find an error and get a corrected bill from your provider, send copies of both bills to UniCare for review. You will get 25% of any savings that result from a confirmed billing error.

What do I need to do?

- ❑ **Submit the completed Bill Checker form** and copies of both the original and corrected bills.
- ❑ **Write your UniCare member ID number** prominently on all the documents that you are sending to UniCare and keep copies for your own records.
- ❑ Note that **duplicate claims and services are not covered** by UniCare and will not be reviewed.
- ❑ Call UniCare Member Services at **833-663-4176** if you have any other questions.

PART A: About the UniCare enrollee					
Last name	First name	MI	Street address		
UniCare ID number (from UniCare ID card)			City	State	ZIP code
PART B: About the medical bill					
Patient name (if different from enrollee)			Date of service		
Name of service provider			Type of service ☐ Inpatient ☐ Outpatient		

Write your member ID on all paperwork.
Send this form and your proof of payment to:

UniCare State Indemnity Plan
PO Box 9016
Andover, MA 01810-0916

You can also fax your paperwork to 978-474-5162 or email it to contact.us@anthem.com.

Diabetes Prevention Program Reimbursement Form

See "Diabetes prevention program reimbursement" on page 45 for details about what is covered under the diabetes prevention program reimbursement.

PART A: About the UniCare enrollee (shown on your UniCare ID card)

Last name	First name	MI	Street address		
UniCare ID number			City	State	ZIP code

PART B: About the UniCare member

Last name	First name	MI	Street address		
Date of birth	Sex ☐ Male ☐ Female		City	State	ZIP code

Member's relationship to UniCare enrollee ☐ Self ☐ Spouse ☐ Child ☐ Other (please specify)

PART C: About the diabetes prevention program

Program name and/or location	Street address		
Program start and end dates	City	State	ZIP code
Amount of reimbursement requested $	Total cost of program $		

I hereby acknowledge that the information I have provided on this form is correct and complete to the best of my knowledge.	Signature	Date

Write your member ID on all paperwork.
Send this form with your proofs of payment and participation to:

UniCare State Indemnity Plan
Diabetes Prevention Program Reimbursement
PO Box 9016
Andover, MA 01810-0916

You can also fax your paperwork to 978-474-5162 or email it to contact.us@anthem.com.

Fitness Reimbursement Form

See "Fitness club reimbursement" on page 53 for details about what is covered under the fitness reimbursement.

What is the fitness reimbursement?

The Plan offers a $100 reimbursement benefit toward a fitness activity. Upon proof of payment, the reimbursement is paid to the Plan enrollee (subscriber).

What types of fitness activities qualify?

Eligible for reimbursement		Not eligible for reimbursement
▪ Boys & Girls Clubs of America ▪ Classes and programs such as yoga, Pilates, and spin (either in-person or online) ▪ Dance classes/studios ▪ Gyms, health clubs, and fitness centers	▪ Martial arts centers ▪ Personal trainers (either in-person and online) ▪ Sports teams ▪ Organizations and leagues designed for fitness activities (e.g., hiking, bowling, etc.)	▪ Annual or day passes (e.g., ski passes) ▪ Dues for beach or country clubs ▪ Fees for one-day events ▪ Personal or home fitness equipment ▪ Spas or spa services

What do I need to do to get reimbursed?

1. Fill out the **Fitness Reimbursement Request** below.
2. Provide **proof of payment** (for example, a copy of your credit card receipt, email confirmation).
3. Send, fax, or email your request and proof of payment to the address shown below the form.

What else should I know?

- We recommend that you **send proof of payment for the entire amount** instead of making several requests for lesser amounts.
- **Write your UniCare member ID number** on all receipts and documents.
- If you have any questions, call UniCare Member Services (**833-663-4176** for Basic, PLUS and Community Choice members or **800-442-9300** for Medicare Extension members).

Fitness Reimbursement Request

Last name	First name	MI	Street address		
UniCare plan ID number	Birth date		City	State	ZIP code

Fitness participant (if different from UniCare enrollee):

Relationship to UniCare enrollee ☐ Self ☐ Spouse ☐ Child ☐ Other (explain):

Name of fitness facility or description of activity	Requested reimbursement amount $

☐ I have engaged in physical activity an average of four or more times per month

By checking the box above and submitting your proof of payment, you verify that you meet all eligibility requirements.	Signature	Date

Send this form and proof of payment to: UniCare Fitness Reimbursement, PO Box 9016, Andover, MA 01810-0916
You can also fax your paperwork to 978-474-5162 or email it to contact.us@anthem.com

Appendix D: Mandates and required member notices

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're 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 programs. If you or your children aren't eligible for Medicaid or CHIP, you won't 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 aren't 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 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, 2021.
Contact your state for further information on eligibility.

Premium assistance under Medicaid and CHIP

ALABAMA – Medicaid

Website: http://myalhipp.com/

Phone: 855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program

Website: http://myakhipp.com/

Phone: 866-251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/

Phone: 855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program

Website: http://dhcs.ca.gov/hipp

Phone: 916-445-8322

Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado website: https://www.healthfirstcolorado.com/

Health First Colorado Member Contact Center: 800-221-3943 / State Relay 711

CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus

CHP+ Customer Service: 800-359-1991/ State Relay 711

Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program

HIBI Customer Service: 855-692-6442

FLORIDA – Medicaid

Website: http://flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html

Phone: 877-357-3268

GEORGIA – Medicaid

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp

Phone: 678-564-1162, ext. 2131

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877-438-4479

All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid website: https://dhs.iowa.gov/ime/members

Medicaid phone: 800-338-8366

Hawki website: http://dhs.iowa.gov/Hawki

Hawki phone: 800-257-8563

HIPP website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp

HIPP phone: 888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/

Phone: 800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx

Phone: 855-459-6328

Email: KIHIPP.PROGRAM@ky.gov

KCHIP website: https://kidshealth.ky.gov/Pages/index.aspx

Phone: 877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 888-342-6207 (Medicaid hotline) or 855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment website:
https://www.maine.gov/dhhs/ofi/applications-forms

Phone: 800-442-6003
TTY: Maine relay 711

Private Health Insurance Premium webpage:
https://www.maine.gov/dhhs/ofi/applications-forms

Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/info-details/masshealth- premium-assistance-pa

Phone: 800-862-4840

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp

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://www.ACCESSNebraska.ne.gov

Phone: 855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid website: http://dhcfp.nv.gov

Medicaid phone: 800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm

Phone: 603-271-5218

Toll free number for the HIPP program:
800-852-3345, ext. 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: https://www.health.ny.gov/health_care/medicaid/

Phone: 800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/

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://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html

Phone: 800-699-9075

PENNSYLVANIA – Medicaid

Website: https://www.dhs.pa.gov/Providers/Pages/Medical/HIPP-Program.aspx

Phone: 800-692-7462

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/

Phone: 855-697-4347 or 401-462-0311
(Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov

Phone: 888-549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov
Phone: 888-828-0059

TEXAS – Medicaid

Website: http://gethipptexas.com/
Phone: 800-440-0493

UTAH – Medicaid and CHIP

Medicaid website: https://medicaid.utah.gov/
CHIP website: http://health.utah.gov/chip
Phone: 877-543-7669

VERMONT – Medicaid

Website: http://www.greenmountaincare.org/
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://www.coverva.org/hipp/
Medicaid phone: 800-432-5924
CHIP phone: 855-242-8282

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/
Phone: 800-562-3022

WEST VIRGINIA – Medicaid

Website: http://mywvhipp.com
Phone: 855-MyWVHIPP (855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800-362-3002

WYOMING – Medicaid

Website:
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility
Phone: 800-251-1269

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877-267-2323, Menu Option 4, Ext. 61565[1]

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

1 OMB Control Number 1210-0137 (expires 1/31/2023)

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 healthcare 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 healthcare provider.

You must notify the Plan within 24 hours – one business day – of being admitted to the hospital. Please call UniCare Member Services at 833-663-4176 if you have questions about these benefits.

Member rights and responsibilities (Beacon Health Options)

Your behavioral health benefits are administered by UniCare in partnership with Beacon Health Options. Beacon maintains contracts with behavioral health providers as well as providing some other administrative services like case management. This section outlines your member rights and responsibilities for services provided by Beacon.

Member rights

Company and provider information

- ❑ You have the right to receive information about Beacon's services, benefits, practitioners, providers, member rights and responsibilities and clinical guidelines.

Respect

- ❑ You have the right to be treated with respect, dignity and privacy regardless of race, gender, veteran status, religion, marital status, national origin, physical disabilities, mental disabilities, age, sexual orientation, or ancestry.
- ❑ You have a right to receive information in a manner and format that is understandable and appropriate. You have the right to oral interpretation services free of charge for any Beacon materials in any language.
- ❑ You have the right to be free from restraint and seclusion as a means of coercion, discipline, convenience, or retaliation.

Member input

- ❑ You have the right to have anyone you choose speak for you in your contacts with Beacon. You have the right to decide who will make medical decisions for you if you cannot make them. You have the right to refuse treatment, to the extent allowed by the law.
- ❑ You have the right to be a part of decisions that are made about plans for your care. You have the right to talk with your provider about the best treatment options for your condition, regardless of the cost of such care, or benefit coverage.
- ❑ You have the right to obtain information regarding your own treatment record with signed consent in a timely manner and have the right to request an amendment or correction be made to your medical records.
- ❑ You have the right to a copy of your rights and responsibilities. You have a right to tell Beacon what you think your rights and responsibilities as a member should be.
- ❑ You have the right to exercise these rights without having your treatment adversely affected in any way.

Complaints

- ❑ You have the right to make complaints (verbally or in writing) about Beacon staff, services or the care given by providers.
- ❑ You have a right to appeal if you disagree with a decision made by Beacon about your care. Beacon administers your appeal rights as stipulated under your benefit plan.

Confidentiality

- ❑ You have the right to have all communication regarding your health information kept confidential by Beacon and UniCare staff and by contracted providers and practitioners, to the extent required by law.

Access to care, services and benefits

- ❑ You have the right to know about covered services, benefits, and decisions about healthcare payment with your plan, and how to seek these services. You have the right to receive timely care consistent with your need for care.

Claims and billing

- ❑ You have the right to know the facts about any charge or bill you receive.

Member responsibilities

- ❑ You have the responsibility to provide information, to the best of your ability, that Beacon or your provider may need to plan your treatment.
- ❑ You have the responsibility to learn about your condition and work with your provider to develop a plan for your care. You have the responsibility to follow the plans and instructions for care you have agreed to with your provider.

- ❑ You are responsible for understanding your benefits, what's covered and what's not covered. You are responsible for understanding that you may be responsible for payment of services you receive that are not included in the covered services list for your coverage type.
- ❑ You have the responsibility to notify the GIC and your provider of changes such as address changes, phone number change, or change in insurance.
- ❑ If required by your benefit, you are responsible for choosing a primary care provider and site for the coordination of all your medical care.
- ❑ You are responsible for contacting your behavioral health provider, if you have one, if you are experiencing a mental health or substance use emergency.

Beacon's *Member Rights and Responsibilities* is available in both English and Spanish from Beacon's website (www.beaconhealthoptions.com). You can also request a copy by calling Beacon at 888-204-5581 (TTY: 711).

Right of reimbursement (subrogation)

These provisions apply when UniCare pays benefits as a result of injuries or illnesses you or your dependent (hereafter "you") sustained and you have a right to a recovery or have received a recovery from any source. A "recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements or court orders characterize, allocate, or designate the money you receive as a recovery, it shall be subject to these provisions. UniCare's rights of subrogation and reimbursement are not subject to application of the made whole or common fund doctrines and UniCare's rights will not be reduced due to your negligence.

Subrogation

UniCare is subrogated to your rights of recovery and has the right to recover payments it makes from any party responsible for compensating you for your illnesses or injuries. UniCare has the right to take whatever legal action it sees fit against such party to recover the benefits it has paid. UniCare's subrogation claim shall be first satisfied before any part of a recovery is applied to your claim, attorney fees, other expenses/costs.

Reimbursement

UniCare has the right to be reimbursed from any recovery you receive in the amount of benefits paid on your behalf. This right of reimbursement will be considered a priority lien by agreement against any recovery. You will not have to reimburse UniCare for any more than the amount UniCare paid in benefits.

Your Duties

You and your legal representative must do whatever is necessary to enable UniCare, or its designee, to exercise its rights and will do nothing to prejudice those rights. You must cooperate with UniCare in the investigation, settlement and protection of its rights.

You agree to promptly notify UniCare of any pursuit of a recovery (filing a lawsuit or otherwise), your retention of a legal representative (if applicable), and the occurrence of a settlement or verdict. You and your legal representative acknowledge that UniCare's lien is automatically created by the terms of this handbook, any recovery will be held in trust, and UniCare shall be immediately repaid from the recovery in the amount of the benefits paid on your behalf.

Appendix E: Your right to appeal

This appendix describes how UniCare handles member appeals in accordance with federal regulations.

For purposes of these appeal provisions, “claim for benefits” means a request for benefits under the Plan. The term includes both pre-service and post-service claims.

- ❑ A pre-service claim is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- ❑ A post-service claim is any other claim for benefits under the plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- ❑ You will be provided with a written notice of the denial or rescission; and
- ❑ You are entitled to a full and fair review of the denial or rescission.

A **rescission** is a retroactive termination of coverage as a result of fraud or an intentional misrepresentation of material fact. A cancellation or discontinuance of coverage is not a rescission if the cancellation has a prospective effect or if the cancellation is due to a failure to timely pay required premiums or contributions toward the cost of coverage.

The procedure UniCare follows satisfies the requirements for a full and fair review under applicable federal regulations.

Notice of adverse benefit determination

If your claim is denied, UniCare’s notice of the adverse benefit determination (denial) will include the following, when applicable:

- ❑ Information sufficient to identify the claim involved;
- ❑ The specific reasons for the denial;
- ❑ A reference to the plan provisions on which UniCare’s determination is based;
- ❑ A description of any additional material or information needed to reconsider your claim;
- ❑ An explanation of why the additional material or information is needed;
- ❑ A description of the plan’s review procedures and the time limits that apply to them;
- ❑ Information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination, and about your right to request a copy of it free of charge;
- ❑ Information about your right to a discussion of the claims denial decision;
- ❑ Information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, and about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- ❑ The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

- ❑ UniCare’s notice will also include a description of the applicable urgent/concurrent review process; and
- ❑ UniCare may notify you or your authorized representative within 24 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination. You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. UniCare's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

UniCare shall offer an appeals process and an external review process. In cases involving eligibility for coverage, you may only appeal; there is no external review. The time frame allowed for UniCare to complete its review is dependent upon the type of review involved (e.g., pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care

You may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including UniCare's decision, can be exchanged by telephone, fax, or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact UniCare at the number shown on your blue UniCare ID card and provide at least the following information:

- ❑ The identity of the claimant;
- ❑ The dates of the medical service;
- ❑ The specific medical condition or symptom;
- ❑ The provider's name;
- ❑ The service or supply for which approval of benefits was sought; and
- ❑ Any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals

All other requests for appeals should be submitted in writing by the member or the member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g., urgent care). You or your authorized representative must submit a request for review to:

UniCare State Indemnity Plan
P.O. Box 2011
Andover, MA 01810

Upon request, UniCare will provide reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- ❑ Was relied on in making the benefit determination; or
- ❑ Was submitted, considered, or produced in the course of making the benefit determination; or
- ❑ Demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- ❑ Is a statement of the plan's policy or guidance about the treatment or benefit relative to your diagnosis.

UniCare will also provide you with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination based on a new or additional rationale, UniCare will provide you with the rationale.

How your appeal will be decided

When UniCare considers your appeal, it will not rely upon the initial benefit determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a healthcare professional who has the appropriate training and experience in the medical field involved in making the judgment. This healthcare professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the outcome of the appeal

If you appeal a claim involving urgent/concurrent care

UniCare will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim

UniCare will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim

UniCare will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

Appeal denial

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from UniCare will include all pertinent information set forth in “Notice of adverse benefit determination” on page 176.

External review

If the outcome of the appeal is adverse to you, you may be eligible for an independent external review pursuant to federal law.

Unless you are filing an expedited external review, you must first file an appeal with UniCare before you can pursue an external review. You must submit your request for external review to UniCare within four months of the notice of UniCare’s adverse determination of your appeal.

A request for an external review must be in writing unless UniCare determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for your appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an expedited external review without filing an appeal or while simultaneously pursuing an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including UniCare’s decision, can be exchanged by telephone, fax, or other similar method.

To proceed with an expedited external review, you or your authorized representative must contact UniCare at the number shown on your blue UniCare ID card and provide at least the following information:

- ❑ The identity of the claimant;
- ❑ The dates of the medical service;
- ❑ The specific medical condition or symptom;
- ❑ The provider's name;
- ❑ The service or supply for which approval of benefits was sought; and
- ❑ Any reasons why the appeal should be processed on a more expedited basis.

All other requests for external review should be submitted in writing unless UniCare determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

UniCare State Indemnity Plan
P.O. Box 2011
Andover, MA 01810

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek external review will not affect your rights to any other benefits under this healthcare plan. The external review decision is final and binding on all parties except for any relief available through applicable state laws.

Requirement to file an appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's appeals process before filing a lawsuit or taking other legal action of any kind against the Plan.

We reserve the right to modify the policies, procedures and time frames in this section upon further clarification from the Department of Health and Human Services and the Department of Labor.

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We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese
您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese
Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean
귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog
May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian
Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian
Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi
"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

French
Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

Arabic
لك الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

Japanese
お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian
Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòma tou.

Italian
Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish
Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi
ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਬਸ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Notes

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