SERIES 5

UNICARE STATE INDEMNITY PLAN COMMUNITY CHOICE

Member Handbook for Active Employees and Non-Medicare Retirees

Effective July 1, 2018

UniCare®

An Anthem Company

Commonwealth of Massachusetts
Group Insurance Commission

UNICARE STATE INDEMNITY PLAN
COMMUNITY CHOICE
MEMBER HANDBOOK

For active employees and non-Medicare retirees

Effective July 1, 2018

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 (www.mahealthconnector.org).

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

THIS DISCLOSURE IS FOR THE MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 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 mass.gov/doi.

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.

Personal Services for Better Health

UniCare is enhancing its customer service to offer members a more personalized experience. Starting this year, when you call UniCare Member Services, you'll speak with a **UniCare health guide** – a specially trained representative who can do a great deal more than just answer your question. Health guides listen and work with you to help resolve issues as quickly as possible, and they can connect you to more resources when needed.

UniCare primary nurses work closely with the health guides to offer members one-on-one help and support, whether you want help in reaching health goals or need support in dealing with a serious medical condition. Once you connect with your primary nurse, he or she will remain the personal health consultant for you and your family – someone you can contact directly with questions or concerns. Your primary nurse may also reach out to you about your health and care, and to offer assistance should an issue arise.

To help you get going, there's UniCare's **Mobile Health** application. You can access Mobile Health from the device you prefer – phone, tablet or computer – and once you're registered, you'll have tools to keep track of your health, your claims, and everything in between.

Your UniCare benefits help protect you when you're facing illness or injury. UniCare's enhanced services – health guides, primary nurses and Mobile Health – are here to help you stay well, at no extra cost to you.

Get connected through Mobile Health	
1. Register with Mobile Health	▪ **From your mobile device:** Go to Google Play or the Apple Store and search for *Mobile Health Consumer* ▪ **From your computer:** Go to mobilehealthconsumer.com and select the *User* button (at the top right)
2. Fill out your health assessment	Select the **Health Assessment** tile and just go from there – it's easy.
Connect with your WellMASS benefits for better health	
Well MASS Commonwealth of Massachusetts Group Insurance Commission	Look for the **WellMASS logo** to find benefits, programs and services that are offered as part of the **GIC's WellMASS wellness program.**

To find out more about UniCare's enhanced Member Services, see pages 133-135.

Who 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)
- **Preapprovals:**
  800-442-9300 / TTY: 711 (toll free)
  7:30 a.m. to 6:00 p.m. (M-Th)
  7:30 a.m. to 5:00 p.m. (F)
- **Email:**
  contact.us@anthem.com
- **Website:**
  unicarestateplan.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 health care provider
- These sections of this handbook:
  - Part 1: Getting Started (pages 13-30)
  - Part 2: Your Medical Benefits (pages 31-82)
  - Part 3: Your Behavioral Health Benefits (pages 83-95)
  - Part 4: Using Your Plan (pages 97-145)

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
- Information from Part 5: Your Prescription Drug Benefits (pages 147-163)

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

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

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List of Tables

PART 1:
GETTING STARTED

Introducing Community Choice

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

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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 4.

What this handbook covers

About the Community Choice plan

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

Your Community Choice 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, customer service, 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/Community Choice.

Community Choice 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 differ depending on the service and the provider, and that not all services are covered by the Plan.

Using Community Choice hospitals

When you need services at a hospital, your benefits are highest at Community Choice hospitals. At non-Community Choice hospitals, you owe higher member costs – and these costs can be significant. See page 27 for an example of what you can owe at Community Choice and non-Community Choice hospitals.

Where to find information in this book

This handbook provides information about the following benefits:

- **Medical services** – These benefits are administered by UniCare.
- **Behavioral health (mental health and substance use disorder) services** – These benefits are administered by UniCare in partnership with Beacon Health Options.
- **Prescription drugs** – These benefits are separately administered by Express Scripts.

Table 1. How this handbook is organized

Part 1: Getting Started (pages 13-30)	
What to know and do to take advantage of plan features *For the medical and behavioral health benefits administered by UniCare*	▪ The features and advantages that Community Choice offers ▪ How to get the most out of your Community Choice coverage ▪ How costs and billing work
Part 2: Your Medical Benefits (pages 31-82)	
Coverage for medical services *For the medical benefits administered by UniCare*	▪ When and how to get medical services preapproved ▪ Medical services covered under this plan ▪ What your preventive benefits are
Part 3: Your Behavioral Health Benefits (pages 83-95)	
Coverage for mental health and substance use disorder services *For the behavioral health benefits administered by UniCare*	▪ General information about your behavioral health coverage ▪ When and how to get behavioral health services preapproved ▪ Behavioral health services covered under this plan
Part 4: Using Your Plan (pages 97-145)	
How to understand and use the features of this plan *For the medical and behavioral health benefits administered by UniCare*	▪ Exclusions and limits on what's covered ▪ Overview of the different kinds of health care providers ▪ Information about claims, preapprovals and other health plan concepts
Part 5: Your Prescription Drug Benefits (pages 147-163)	
Coverage for prescription drugs *For the pharmacy benefits administered by Express Scripts*	▪ General information about your prescription drug coverage ▪ What your coverage is for prescription drugs
Part 6: Appendices (pages 165-188)	
Reference material and notices	▪ GIC notices, forms, state and federal mandates, your appeal rights

A note about terms and definitions

Definitions for many of the terms used in this handbook appear in Chapter 14 (pages 139-145). You should also keep in mind that:

- ❑ The official name of your plan is **UniCare State Indemnity Plan/Community Choice**. In this handbook, we sometimes refer to it as the **Community Choice plan**, **Community Choice**, or **the Plan**.
- ❑ We sometimes 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** are those services covered by the medical benefits described in Part 2 of this handbook. **Behavioral health services** are those services covered under the benefits described in Part 3. **Health care services** applies to both medical and behavioral health services.

Symbols used in this handbook

	**Important information** – This may have an impact on your benefits.
	**No coverage, limited coverage, or benefit restriction** – A full list of Plan exclusions and limitations appears in Chapter 10.
	**Needs preapproval** – You (or someone acting for you) must tell UniCare if you are having this service. See pages 32-35 for preapproval for medical services, and pages 85-86 for preapproval for behavioral health services.
	**Use UniCare preferred vendors** – To get the best benefit, use a UniCare preferred vendor for this service or product. See page 112 to learn more.
	**Check the website** – Information about this topic can be found at unicarestateplan.com.

Do you have other health insurance?

If you or a family member is covered under another health plan, you must tell UniCare. If you haven't already done so, be sure to fill out and return the *Other Health Insurance* (OHI) form. However, you don't need to send in the OHI form if your other coverage is from one of the following:

- ❑ AARP
- ❑ MassHealth
- ❑ TRICARE

If you have health coverage from any other insurer and haven't yet sent in the OHI form, you can download the form from unicarestateplan.com. Or call UniCare Member Services at 833-663-4176 and ask that the form be sent to you.

To learn more about how UniCare coordinates benefits with other health plans, turn to "Coordinating benefits with other health plans (COB)" on page 129.

About your ID card

Every Community Choice member will get a UniCare ID card. Your ID card has useful information about your benefits, as well as important telephone numbers you and your health care providers may need.

If you lose your UniCare ID card or need additional cards, you can order them from unicarestateplan.com. Or call UniCare Member Services at 833-663-4176 for help.

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.

Sometimes, you need to get preapproval

You need to get preapproval if you're going to have a service that has a preapproval requirement. If you don't, you could lose as much as $500 of your benefits. In this handbook, the **telephone** ☎ marks services that need to be preapproved.

For more information about preapprovals…	
☎ **Medical services that need preapproval**	See pages 32-35
☎ **Behavioral health services that need preapproval (mental health and substance use disorder)**	See pages 85-86

Getting the most out of Community Choice

For a description of the different kinds of providers and facilities mentioned in the table below, see "Types of health care providers" on pages 110-113.

Table 2. How to get the most out of Community Choice

Tips on choosing providers		See pages
Use Community Choice hospitals	At Community Choice hospitals: ▪ Your copays are lower ▪ Inpatient care and outpatient surgery is covered at 100% Non-Community Choice hospitals are covered at 80% which means you'll owe 20% coinsurance (up to a $5,000 limit). And your copays are higher too.	111, 172
Choose a PCP in a patient-centered primary care practice	You have a $15 copay when your PCP participates in UniCare's **Patient-Centered Primary Care** program. For other PCPs, the copay is $20.	110
Use Tier 1 or Tier 2 specialists	Your copays are lower when you use specialists who are Tier 1 or Tier 2.	50, 114-115
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.	53-54, 112
Have outpatient services at non-hospital-owned sites	There's no copay when you have outpatient surgery at an independent ambulatory surgery center (not run by a hospital).	74-76, 113
✓ **Use UniCare 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** ✓ identifies services with a preferred vendor benefit.	112
Use Beacon Health Options in-network providers for behavioral health services	Beacon in-network providers won't balance bill you for charges over the Plan's allowed amount.	84

Getting care outside of Massachusetts		See pages
Use contracted providers outside of Massachusetts	If you travel outside of Massachusetts, be sure to use contracted providers when you need medical services. Contracted providers have agreed to accept UniCare's payment as payment in full – they won't balance bill you. (In Massachusetts, you're free to use any provider.)	113
Have your out-of-state dependents use contracted providers too	Covered dependents who live outside of Massachusetts should also use contracted providers when they need medical services.	113
Other ways to keep your costs down		**See pages**
Compare costs and get cash back with SmartShopper	**SmartShopper** lets you compare costs for common procedures with Massachusetts providers. You can earn a cash reward of up to $500 when you use a cost-effective provider.	137
LiveHealth Online telehealth	From your computer or mobile device, you can reach a doctor anytime, day or night, for a $15 copay.	112

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 medical 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 a lot of separate charges on a medical bill.
- **Not all medical 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 insurance doesn't cover. Also, most insurance plans have a list of services that are *excluded* (never covered). You can find the list of excluded services in Chapter 10.
- **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, but 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**.

  What is a provider? A **health care provider** is a person, place, or organization that delivers medical 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 owe a fee, called a **copay**, at the doctor's office. When you pay something toward the medical 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 may also be 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 are for different services. The three types of member costs are:

- **Deductible (page 21)** – A set dollar amount you pay toward services each year before the Plan starts paying benefits for those services.
- **Copays (pages 22-27)** – A copay, or copayment, is a fixed amount you pay when you get certain medical services.
- **Coinsurance (page 27)** – For some services, the Plan pays 80% and you pay the other 20%. The 20% that you owe is called coinsurance.

☞ **Important!** You have different copays and coinsurance for certain services at Community Choice and non-Community Choice hospitals. Always use Community Choice hospitals to get the maximum benefit. Appendix B lists all the Community Choice hospitals.

There are limits on how much you could pay each plan year for these member costs. **Out-of-pocket maximums** cap how much you'll spend each plan year on the combination of deductible, copays and coinsurance. See pages 27-28 to learn about the **out-of-pocket maximums** and the **non-Community Choice coinsurance limit**.

> **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 medical services that you or someone in your family had, we subtract any member costs you owe from the amount we pay to that provider. 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 your member costs. In other words, the provider will bill you for any copay, deductible and/or coinsurance that UniCare subtracted from the payment we made. (If you had any services 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 medical 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 deductible starts on July 1 each year (in other words, at the start of the plan year). Depending on how much a claim is for, it may take more than one claim before a deductible is *satisfied* (fully paid). Once you have paid all of this year's deductible, you won't owe any more deductible until the next plan year starts.

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

Your deductible applies to medical and behavioral health services. A separate deductible applies to prescription drugs. Part 5 of this handbook describes your prescription drug plan.

Table 3. How much is my deductible?

Deductible amounts	
For an individual	**$400 for one person**
For a family	**$800 for the entire family** *For any one person in the family, the deductible is capped at $400*

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.

> **Example** – In July, you get services and pay $200 toward your deductible. You now have $200 of your deductible that you haven't paid yet. In August, you get more services. If this second bill is *more* than $200, you pay the $200 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 $200, you'll owe the rest of your deductible next time you have services that the deductible applies to.

How a family deductible works

If you have dependents who are covered under your plan, then you also have a **family deductible**. The family deductible is the maximum amount that your family could pay in a plan year. The most you'll owe for any one family member is $400, until the family as a whole reaches the $800 family limit.

> **Example** – In July, you and your two children get services and each of you pay $250 deductibles. This means you've paid $750 of your family deductible. In August, your spouse gets services and pays $50 deductible – the rest of your family deductible. Even though no one person has reached the $400 cap, you've paid the entire $800 family deductible. You won't have to pay any more deductible for anyone in your family for the rest of the plan year.

About copays

A **copay** is a fixed amount you pay when you get certain services. For example, you pay a copay when you see your doctor for a sore throat, or when you get outpatient hospital surgery. The dollar amount of a copay depends on the service you're getting, what kind of provider you use and whether you're using a Community Choice or non-Community Choice hospital (when you need hospital services). The tables in this section list the Plan's copays and the services they apply to.

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. Inpatient hospital care and outpatient surgery at non-Community Choice hospitals also 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 hospital care and outpatient surgery at Community Choice hospitals have quarterly copays, as do behavioral health acute care services.

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

Copays for provider visits

You owe a copay each time you see a health care provider for any of the services listed in Table 4. These provider visits include visits to the doctor (a primary care provider or specialist), and other types of provider visits (for example, sessions with a physical therapist or chiropractor).

The amount of the copay depends on the type of provider you're going to and, in the case of a specialist visit, on the specialist's tier assignment.

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.

Table 4. Copays for provider visits

Type of provider visit	Copay
Primary care – *With a PCP (primary care physician, nurse practitioner, or physician assistant)*[1]	$20
Primary care at a patient-centered primary care practice (page 110) – *With a PCP (primary care physician, nurse practitioner, or physician assistant)*[1]	$15

1 A **primary care provider (PCP)** can be a nurse practitioner, physician assistant or physician whose specialty is family medicine, general medicine, pediatrics, geriatrics or internal medicine.

Type of provider visit	Copay
Specialist – *With a doctor in Massachusetts*	
▪ ***Tier 1 (excellent)	$30
▪ **Tier 2 (good)	$60
▪ *Tier 3 (standard)	$75
▪ Not tiered1	$60
Specialist – *With a doctor outside Massachusetts*	$60
Specialist – *With a nurse practitioner or physician assistant*	$60
Routine eye exam	
▪ With an optometrist	$60
▪ With an ophthalmologist	See specialists (above)
☎ **Physical therapy**	$15
☎ **Occupational therapy**	$15
☎ **Chiropractic care**	$15
LiveHealth Online telehealth (page 112)	$15

Copays for services at hospitals and other facilities

You owe a copay when you have any of the services listed in Table 5.

Table 5. Copays at hospitals and other facilities

Service	At Community Choice hospitals	At other hospitals
Urgent care center visit	$20	
Retail health clinic visit	$20	
Emergency room (ER) *Copay waived if admitted to the hospital*	$100	$100
☎ **Inpatient hospital care** *Copay waived if readmitted within 30 days of discharge, within the same plan year*	$275 per quarter	$750 per admission
☎ **Inpatient hospital (limited circumstances)**		
▪ Admitted from the emergency room	$275 per quarter	$275 per quarter
▪ Neonatal ICU at a designated hospital (see page 64)	$275 per quarter	$275 per quarter
▪ Transplant at a Quality Center or Designated Hospital (see page 78)	$275 per quarter	$275 per quarter

1 These are specialists who don't have enough data to allow us to score them, such as doctors who are new to practice.

Service	At Community Choice hospitals	At other hospitals
☎ **Outpatient surgery**		
▪ Outpatient hospital	$110 per quarter	$250 per visit
▪ Non-hospital-owned location	No copay	
☎ **High-tech imaging** *Such as MRIs, CT scans and PET scans*		
▪ Hospital outpatient	$100 per day	$200 per day
▪ Non-hospital-owned location	$100 per day	
Other radiology and lab services		
▪ Hospital outpatient	No copay	$50 per day
▪ Non-hospital-owned location	No copay	

About the emergency room (ER) copay

You owe this copay each time you go to a hospital emergency room. If you are admitted to the hospital from the ER, this copay is waived.

The inpatient hospital copay: Community Choice hospitals

You owe an inpatient hospital copay when you are admitted to a Community Choice hospital. This is a per-person quarterly copay, so you only owe the amount of one copay in a calendar quarter.

> **Example** – You are admitted to a Community Choice hospital in July and stay overnight, so you owe an inpatient hospital copay. If you are readmitted to a Community Choice hospital in September, you won't owe another copay because July and September are in the same calendar quarter. But if you are readmitted in November, you will have to pay a copay again.

The inpatient hospital copay: non-Community Choice hospitals

At non-Community Choice hospitals, the inpatient hospital copay is a per-admission inpatient copay. You pay this copay each time you are admitted to a non-Community Choice hospital (except for certain limited circumstances mentioned below). You'll also owe 20% coinsurance (up to a limit of $5,000) when you get inpatient services at a non-Community Choice hospital.

> **Example** – You are admitted to a non-Community Choice hospital in July and stay overnight, so you owe the non-Community Choice inpatient hospital copay. If you are readmitted to a non-Community Choice hospital in September, you must pay another copay even though both visits are in the same calendar quarter.

The inpatient hospital copay: limited circumstances

Under the following limited circumstances, you owe the Community Choice inpatient hospital quarterly copay, even at a non-Community Choice hospital:

- ❑ You are admitted to a hospital from the emergency room
- ❑ You go to a designated hospital for neonatal ICU services (page 64)
- ❑ You have a transplant at a Quality Center or Designated Hospital for transplants (page 78)

If you are readmitted to the hospital within 30 days

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

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

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

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

If you also owe a behavioral health acute care copay

If you owe both an inpatient hospital quarterly copay (at Community Choice hospitals) and a behavioral health acute care copay (page 26) in the same calendar quarter, you owe the amount of the higher copay, but you won't owe two copays.

> **Example** – In July, you get behavioral health acute care services, so you owe the $200 quarterly copay. In September, you are admitted to a Community Choice hospital for medical care. Since both admissions are within the same quarter, you don't owe two separate copays. But you do owe the amount of the higher copay which, in this case, is the $275 Community Choice inpatient hospital copay.

The outpatient surgery copay: Community Choice hospitals

You owe the outpatient surgery copay when you have outpatient surgery at a Community Choice hospital or at a location owned by a Community Choice hospital. This is a per-person quarterly copay, which means you only have to pay it one time in a calendar quarter.

The outpatient surgery copay: non-Community Choice hospitals

When you have outpatient surgery at a non-Community Choice hospital, you owe a per-person, per-visit copay. You must pay this copay each time you have surgery at one of these hospitals. You also owe 20% coinsurance (up to a limit of $5,000) at non-Community Choice hospitals.

The outpatient surgery copay: non-hospital locations

You do not owe an outpatient surgery copay when you have surgery at a non-hospital-owned location such as a non-hospital-owned 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 by or operated by a hospital. Non-hospital-owned locations include many ambulatory surgery centers and doctor's offices.

The outpatient high-tech imaging copay

You owe the high-tech imaging copay when you have a high-tech imaging procedure. The copay is lower when you go to a Community Choice hospital or a non-hospital location. High-tech imaging procedures include MRIs, CT scans, and PET scans. You only owe this copay once a day, even if you have more than one high-tech imaging procedure on the same day.

The outpatient radiology and labs copay

You owe a $50 copay when you have other radiology services (like an X-ray) or have lab work done at non-Community Choice hospitals. If you go to a Community Choice hospital or non-hospital location instead, you won't have a copay.

Copays for behavioral health services

You owe a copay when you have any of the behavioral health services listed in Table 6.

Important! Copays for behavioral health services depend on whether or not you use a provider in the Beacon Health Options network (see page 84).

Table 6. Behavioral health copays

Behavioral health service	Copay with in-network providers	Copay with out-of-network providers
☎ **Behavioral health acute care services** *Copay waived if you get more acute care services within 30 days, within the same plan year*	$200 per quarter	$200 per quarter
LiveHealth Online telehealth	$15	*Not applicable*
Medication management	$15	$30
☎ **Outpatient services**	$20	$30
Therapy (outpatient)		
▪ Family therapy	$20	$30
▪ Group therapy	$15	$30
▪ Individual therapy	$20	$30

About the acute care copay

You owe a quarterly copay for behavioral health acute care services. This is a quarterly copay, so you only pay it once in a calendar quarter. This copay applies to both inpatient and outpatient behavioral health acute care. For a list of behavioral health acute care services, see pages 88-89.

If you get acute care services within 30 days of having had other acute care services, you won't have to pay another copay (as long as the services are in the same plan year). This is true even if you get the services in different calendar quarters.

If you owe both a behavioral health acute care copay and a Community Choice inpatient hospital copay in the same calendar quarter, you owe the amount of the higher of the two copays, but you won't owe both copays (see the example on page 25).

About the outpatient services copay

You owe a copay each time you have one of the behavioral health outpatient services listed on page 93.

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%.

When you use a non-Community Choice hospital

When you have inpatient hospital care or outpatient surgery at a non-Community Choice hospital, you will owe 20% coinsurance. This means that your member costs are significantly higher at a non-Community Choice hospital. Table 7 compares your member costs for an inpatient stay at Community Choice and non-Community Choice hospitals.

Table 7. Comparison of inpatient hospital costs

	Community Choice	Non-Community Choice
Deductible	$400	$400
Inpatient hospital copay	$275 quarterly copay	$750 per-admission copay
Coinsurance	None	Up to $5,000
Total member costs	**$675**	**$6,150**

About out-of-pocket maximums

There are limits on how much member costs you have to pay each year toward covered services. These are called **out-of-pocket maximums**. An out-of-pocket maximum is the total dollar amount you could pay in a plan year for member costs (deductible, copays and coinsurance). Once you reach the maximum, the Plan pays 100% of the allowed amounts for covered services for the rest of the plan year.

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

- The **Community Choice out-of-pocket maximum** caps your costs for medical services at Community Choice hospitals, non-hospital medical services, prescription drugs, and in-network behavioral health services (Table 8).
- The **non-Community Choice coinsurance limit** for services at non-Community Choice hospitals (Table 9).
- The **out-of-pocket maximum on out-of-network behavioral health** costs (Table 10).

Table 8. Community Choice out-of-pocket (OOP) maximum

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

Which costs count toward the Community Choice OOP maximum?

- Deductibles
- Copays and coinsurance for non-hospital medical services
- Copays and coinsurance for services at Community Choice hospitals
- Copays for prescription drugs
- Copays and coinsurance for in-network behavioral health services

Which costs do not count toward the Community Choice OOP maximum?

- Copays for services at non-Community Choice hospitals
- Coinsurance for services at non-Community Choice hospitals (see Table 9)
- Copays and coinsurance for out-of-network behavioral health services (see Table 10)

Table 9. Non-Community Choice coinsurance limit

How much is this limit?	
For an individual	$5,000 per person each plan year
For a family	No family limit

Which costs count toward this limit?

- Coinsurance for services at non-Community Choice hospitals

Table 10. OOP maximum on out-of-network behavioral health costs

How much is this OOP maximum?	
For an individual	$3,000 per person each plan year
For a family	No family maximum

Which costs count toward this OOP maximum?

- Copays and coinsurance for out-of-network behavioral health services

Important! The following costs ***never*** apply to any out-of-pocket maximums:

- ❑ 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 providers for services based on the **allowed amount** – that is, the maximum amount that the Plan pays for covered health care services. The Plan has established allowed amounts for most services from providers.

About balance billing

The allowed amount for a given service may not be the same as what a provider actually 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, and balance bills don't count toward your out-of-pocket maximums.

When you get care in Massachusetts

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 in Massachusetts who aren't in the Beacon Health Options network may balance bill you. Since the Plan doesn't cover balance bills, payment is your responsibility. If you need help finding an in-network provider, contact UniCare Member Services at 833-663-4176.

If you have a continuing relationship with a therapist who is not in the Beacon network, 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, providers may balance bill you for the difference between the Plan's allowed amount and the provider's charges. Since the Plan doesn't cover balance bills, payment is your responsibility.

To avoid getting balance billed outside of Massachusetts, use contracted providers when you need medical services. Contracted providers have agreed to accept the Plan's payment as payment in full. Contracted providers will not balance bill you.

For behavioral health services, you won't be balance billed if you use providers in the Beacon Health Options network. See Part 3 (pages 83-95) for information about your behavioral health benefits.

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 providers are not allowed to balance bill UniCare members:

- ❑ Medical providers in Massachusetts
- ❑ Preferred vendors
- ❑ Contracted providers outside of Massachusetts
- ❑ Providers in the Beacon Health Options network

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.

PART 2:
YOUR MEDICAL BENEFITS

Description of coverage for medical services

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

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Chapter 3: Getting preapproval for medical services

About preapproval

Preapproval confirms that a service you're getting will be eligible for benefits. By getting a service preapproved, you reduce your risk of having to pay for a service that isn't covered.

Usually, your doctor will take care of getting a service preapproved, but not always. If you don't get preapproval for a service that requires it, your benefits may be reduced by up to $500, and you risk having to pay the entire cost of the service yourself.

How to request preapproval

When you know you'll be getting a service that needs to be preapproved, you (or your doctor) must submit a request ahead of time. This allows time to review the service to make sure it's eligible for benefits.

For some services, you need to contact UniCare. For other services, such as diagnostic imaging or specialty drugs, your doctor must contact **AIM Specialty Health®**. AIM is a UniCare-affiliated company that provides support for UniCare's preapproval process.

Notifying UniCare

For services that UniCare reviews, contact UniCare at:

800-442-9300 (toll free)
TTY: 711

Notifying AIM Specialty Health

Some preapprovals are handled by **AIM Specialty Health**, a UniCare-affiliated company that provides support for the review process. For AIM reviews, your doctor must contact AIM at:

AIM Specialty Health
866-766-0247 (toll free)
www.providerportal.com

Information you need to provide

You should have the following information ready when you call:

- ❑ **Who the UniCare enrollee is** – The name and UniCare ID number of the Plan enrollee
- ❑ **Who is having the service** – The name, birth date, and contact information of the person having the service. This may be the Plan enrollee (subscriber) or the enrollee's dependent
- ❑ **What the service is** – The service or procedure, the diagnosis, and the scheduled date
- ❑ **Where the service will take place** – The name and contact information for the facility
- ❑ **Who the ordering doctor is** – The doctor's name and contact information

Medical services that need preapproval

Table 11 lists medical services and procedures that need preapproval. The table also shows:

- ❑ **Minimum notice** – How far in advance you must give notice (for example, at least one business day or seven calendar days before the service takes place)
- ❑ **Notify** – Whether you need to notify UniCare or AIM Specialty Health

Because this list may change, check www.unicarestateplan.com/mancarenotifreq.html for the most up-to-date list.

Preapprovals for behavioral health services – See pages 85-86 for information about preapprovals for behavioral health services.

Important points to remember

- ❑ **If you don't provide notice within the time shown in Table 11, your benefits may be reduced by up to $500.**
- ❑ **Submitting a claim for service does not meet these requirements. You must notify UniCare (or AIM) *before* the service takes place.**
- ❑ **You don't need to seek preapproval if you are outside the continental United States (all states but Alaska and Hawaii).**
- ❑ **In this handbook, the telephone ☎ marks services that need to be reviewed.**
- ❑ **If you're not sure if you need to get preapproval, ask your doctor to check the list, or call UniCare at 800-442-9300 to find out.**

Preapproval requirements for medical services

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

Table 11. When to get preapproval for medical services

Medical service / procedure	Minimum notice	Notify
✓ BPAP and CPAP equipment	1 business day	AIM
Chiropractic care and osteopathic manipulative therapy for children under 13	1 business day	UniCare
Cleft palate and cleft lip services	7 days	UniCare
✓ Durable medical equipment (DME) costing more than $1,000, except oxygen and oxygen equipment	1 business day	UniCare
Echocardiology ▪ Resting transthoracic echocardiography ▪ Stress echocardiography ▪ Transesophageal echocardiography	7 days	AIM
✓ Enteral therapy	1 business day	UniCare
Gender reassignment surgery	21 days	UniCare
Genetic testing For a current list of genetic tests that require preapproval, go to www.unicarestateplan.com/pdf/GeneticTesting.pdf.	7 days	AIM
High-tech imaging ▪ CT/CTA scan ▪ MRI/MRA scan ▪ Nuclear cardiology ▪ PET scan ▪ SPECT scan	7 days	AIM
✓ Home health care	1 business day	UniCare
Hospital admissions – Elective	7 days	UniCare
Hospital admissions – Emergency or maternity	Within 24 hours (or next business day)	UniCare
Hospital observation stays	Within 24 hours (or next business day)	UniCare
Hyaluronic acid injections of the knee	7 days	UniCare
Hyperbaric oxygen therapy	7 days	UniCare
Occupational therapy	1 business day	UniCare
Physical therapy	1 business day	UniCare
Private duty nursing	1 business day	UniCare

Medical service / procedure	Minimum notice	Notify
Radiation therapy ▪ Brachytherapy ▪ CyberKnife ▪ IMRT ▪ Proton beam ▪ Traditional radiation	7 days	AIM
Skilled nursing facility admissions	Within 24 hours (or next business day)	UniCare
Sleep studies (including polysomnography)	7 days	AIM
Specialty drugs	7 days	AIM
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). Specialty drugs may be covered by either UniCare or by your prescription drug plan. For a current list of drugs that require preapproval through UniCare, go to www.unicarestateplan.com/pdf/SpecialtyDrugList.pdf. For a list of (non-oncology) specialty drugs that require preapproval through the prescription drug plan, see Part 5 of this handbook. Also see the entries for **Drugs** on pages 100-101.		
Surgery ▪ Cardioverter-defibrillator implantation ▪ Cervical fusion ▪ Discectomy – lumbosacral spine (open, percutaneous and endoscopic, and other minimally invasive procedures to treat back pain) ▪ Knee arthroscopy ▪ Knee meniscal transplant ▪ Laminectomy/laminotomy of the lumbosacral spine ▪ Sinus surgery (including endoscopy) ▪ Spinal cord stimulator and neuromodulator implantation ▪ Spinal fusion of the lumbosacral spine ▪ Spinal instrumentation of the lumbosacral spine ▪ Upper gastrointestinal endoscopy ▪ Vertebroplasty	7 days	UniCare
Transplants, except cornea transplants	21 days	UniCare
Varicose vein treatment (including sclerotherapy)	7 days	UniCare
Virtual colonoscopy (colonography)	7 days	UniCare

Chapter 4: Summary of your costs for medical services

For a description of the symbols that appear in this table, see page 16.

Table 12. Summary of covered medical services

Service	Member costs		See page
Ambulances	Deductible		41
Behavioral health services (mental health and substance use disorder)	See Part 3 (pages 83-95) for benefits information.		83
Bereavement counseling	Deductible and 20% coinsurance (limited to $1,500 for a family in a plan year)		61
Cardiac rehab programs	Deductible		42
Chemotherapy	Deductible		43
☎ **Chiropractic care**	$15 copay and 20% coinsurance (limited to 20 visits in a plan year)		43
✓ **Diabetic supplies**	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance		48
Dialysis	Deductible		49
Doctors – office visits ▪ Patient-centered primary care (PCP) visits	$15 copay		50
▪ Other PCP visits	$20 copay		
▪ Specialist visits	$30/60/75 copay		
▪ LiveHealth Online telehealth	$15 copay		
Doctors – other	**Community Choice**	**Non-Community Choice**	50
▪ Emergency room care	Deductible	Deductible	
▪ Inpatient hospital care	Deductible	Deductible	
▪ Outpatient hospital care	$30/60/75 copay	$30/60/75 copay	

To be covered, services must be medically necessary.
Benefits are limited to the Plan's allowed amounts for the services (page 29).

Service	Member costs		See page
Drug screening (lab tests) ▪ Outpatient hospital	**Community Choice** Deductible	**Non-Community Choice** $50 daily copay and deductible	51
▪ Non-hospital lab	Deductible		
☎ ✓ **Durable medical equipment (DME)**	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance		51
Early intervention programs	No member costs		52
Emergency room	$100 copay and deductible		53
Eye exams (routine)	$30/60/75 copay (limited to one exam every 24 months)		55
Eyeglasses and contact lenses	Deductible and 20% coinsurance (limited to the first set within six months of eye injury or cataract surgery)		56
Family planning services	No member costs		56
Fitness club reimbursement	Reimbursed up to $100 for the family in a plan year		57
Hearing aids ▪ Age 21 and under	No member costs (limited to $2,000 for each impaired ear every 24 months)		58
▪ Age 22 and over	No member costs for first $500, then 20% coinsurance of the next $1,500 (up to a limit of $1,700 every 24 months)		
Hearing exams	$15/20/30/60/75 copay		59
☎ ✓ **Home health care**	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance		59
✓ **Home infusion therapy**	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance		60
Hospice care	Deductible		60

To be covered, services must be medically necessary.
Benefits are limited to the Plan's allowed amounts for the services (page 29).

Service	Member costs		See page
☎ **Hospital admissions (inpatient services)**	**Community Choice**	**Non-Community Choice**	62
▪ At a hospital or rehab facility (semi-private room)	$275 quarterly copay and deductible	$750 per-admission copay, deductible and 20% coinsurance	
▪ At a hospital or rehab facility (medically necessary private room)	▪ **First 90 days:** $275 quarterly copay and deductible ▪ **After 90 days:** Dollar difference between the semi-private room rate and the private room rate	▪ **First 90 days:** $750 per-admission copay, 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	$275 quarterly copay and deductible	▪ **At designated hospitals:** $275 quarterly copay and deductible ▪ **At other hospitals:** $750 per-admission copay, deductible and 20% coinsurance	
▪ At a skilled nursing or long-term care facility	Deductible and 20% coinsurance (limited to 45 days in a plan year)	Deductible and 20% coinsurance (limited to 45 days in a plan year)	
Immunizations (vaccines)	No member costs (you may have costs for an office visit)		64
Lab services	**Community Choice**	**Non-Community Choice**	66
▪ Emergency room	Deductible	Deductible	
▪ Inpatient hospital	Deductible	Deductible and 20% coinsurance	
▪ Outpatient hospital	Deductible	$50 daily copay and deductible	
▪ Non-hospital-owned location	Deductible		
Medical services, if not listed elsewhere	Deductible and 20% coinsurance		66
☎ **Occupational therapy**	$15 copay		67
Office visits			50
▪ Patient-centered primary care (PCP) visits	$15 copay		
▪ Other PCP visits	$20 copay		
▪ Specialist visits	$30/60/75 copay		
▪ LiveHealth Online telehealth	$15 copay		

To be covered, services must be medically necessary.
Benefits are limited to the Plan's allowed amounts for the services (page 29).

Service	Member costs		See page
Outpatient services, if not listed elsewhere	Deductible		67
✓ **Oxygen**	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance		68
Personal Emergency Response Systems (PERS) ▪ Installation	Deductible and 20% coinsurance (limited to $50 in a plan year)		68
▪ Rental	Deductible and 20% coinsurance (limited to $40 a month)		
☎ **Physical therapy**	$15 copay		69
Prescription drugs	Benefits are administered by Express Scripts and are described in Part 5 (pages 147-163). Call Express Scripts at 855-283-7679 for more information.		147
Preventive care *See Table 16 on page 79.*	No member costs		79
☎ **Private duty nursing in a home setting**	Deductible and 20% coinsurance (limited to $8,000 in a plan year)		70
Prosthetics and orthotics ▪ Breast prosthetics	Deductible		71
▪ Other prosthetics and orthotics	Deductible and 20% coinsurance		
☎ **Radiation therapy**	Deductible		72
Radiology and imaging ▪ Emergency room	**Community Choice** Deductible	**Non-Community Choice** Deductible	72
▪ Inpatient hospital	Deductible	Deductible and 20% coinsurance	
▪ ☎ High-tech imaging – outpatient hospital	$100 daily copay and deductible	$200 daily copay and deductible	
▪ Other radiology – outpatient hospital	Deductible	$50 daily copay and deductible	
▪ ☎ High-tech imaging – non-hospital-owned location	$100 daily copay and deductible		
▪ Other radiology – non-hospital-owned location	Deductible		
Retail health clinic visits	$20 copay		53
Speech therapy	No member costs (limited to 20 visits in a plan year)		74

To be covered, services must be medically necessary.
Benefits are limited to the Plan's allowed amounts for the services (page 29).

Service	Member costs		See page
☎ **Surgery** ▪ Inpatient hospital	**Community Choice** Deductible (you also have an inpatient hospital copay)	**Non-Community Choice** Deductible and 20% coinsurance (you also have an inpatient hospital copay)	74
▪ Outpatient hospital	$110 quarterly copay and deductible	$250 per-visit copay, deductible, and 20% coinsurance	
▪ Non-hospital-owned location	Deductible		
Tobacco cessation counseling	No member costs (limited to 300 minutes in a plan year)		76
☎ **Transplants** ▪ At a Quality Center or Designated Hospital for transplants	**Community Choice** $275 quarterly copay and deductible	**Non-Community Choice** $275 quarterly copay and deductible	77
▪ At other hospitals	$275 quarterly copay, deductible, and 20% coinsurance	$750 per-admission copay, deductible, and 20% coinsurance	
Urgent care center visits	$20 copay		53

To be covered, services must be medically necessary.
Benefits are limited to the Plan's allowed amounts for the services (page 29).

Chapter 5: Covered medical services

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).

	Member costs
Shot (injection)	Deductible
Allergy serum	Deductible and 20% coinsurance
Office visit	▪ **With a PCP:** $15/20 copay ▪ **With a specialist:** $30/60/75 copay

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.

	Member costs
Ambulance transportation	Deductible

✕ Restrictions:

- The ambulance services must be medically necessary and take you to the nearest hospital that can treat your emergency condition.
- Transfers by ambulance are only covered if you are in a facility that cannot treat your condition, and only to the nearest facility that can provide 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 a medical emergency.
- Transportation in chair cars or vans is not covered.
- There is no coverage for charges for ambulance calls that are then refused.
- Transfers between facilities for behavioral health services are covered if the Plan has requested and arranged for it.

Anesthesia

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

	Member costs
Anesthesia and its administration	Deductible

✕ Restrictions:

- Other charges associated with ECT are covered under your behavioral health benefit. See Part 3 of this handbook (pages 83-95) for benefits information.
- 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, 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 (page 90).

Behavioral health services

Benefits for mental health and substance use disorder services are called **behavioral health services**. See Part 3 of this handbook (pages 83-95) for benefits information.

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.

	Member costs
Cardiac rehab programs	Deductible

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.

	Member costs
Outpatient	Deductible
Inpatient	Covered under the benefit for hospital admissions (page 62)

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.

	Member costs
☎ **Chiropractic care**	$15 copay 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.

☎ **Members under age 13 need preapproval** – Contact UniCare at 800-442-9300 at least one business day before services start for a member under 13. You don't need preapproval if the member is 13 or older.

Circumcision

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

	Member costs
Circumcision	Deductible

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** – Contact UniCare at 800-442-9300 at least seven days before services start and ask to speak with a primary nurse. (See pages 134-135 for more information about primary nurses.)

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:

1. The clinical trial is to study potential treatments for cancer.
2. The clinical trial has been peer reviewed and approved by one of the following:
   - ❑ The United States National Institutes of Health (NIH)
   - ❑ A cooperative group or center of the NIH
   - ❑ A qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants
   - ❑ The United States Food and Drug Administration (FDA) pursuant to an investigational new drug exemption
   - ❑ The United States Departments of Defense or Veterans Affairs
   - ❑ With respect to Phase II, III and IV clinical trials only, a qualified institutional review board
3. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that experience.
4. With respect to Phase I clinical trials, the facility must be an academic medical center (or an affiliated facility) at which the clinicians conducting the trial have staff privileges.
5. The member meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.
6. The member has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.
7. The available clinical or pre-clinical data provide a reasonable expectation that the member's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial.
8. The clinical trial does not unjustifiably duplicate existing studies.
9. The clinical trial must have a therapeutic intent and must, to some extent, assume the effect of the intervention on the member.

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

- ❑ All services that are medically necessary for treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan.

- ❑ 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-health care services that you may be required to receive as a result of participation in the clinical trial
  - Costs associated with managing the research of the clinical trial
  - Costs that would not be covered for non-investigational treatments
  - Any item, service or cost that is reimbursed or furnished by the sponsor of the 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 following situations:

- ❑ **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 44) – 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.

	Member costs
Diabetes prevention program reimbursement	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 form in Appendix C to submit a request for this reimbursement. You can also download the form from unicarestateplan.com, or call UniCare Member Services at 833-663-4176 to request a copy.

✕ 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.

	Member costs
✓ **Diabetic supplies**	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** 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) and many supplies are covered under your prescription drug plan. See Part 5 of this handbook (pages 147-163).

✕ 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.

☎ **Equipment costing more than $1,000 needs preapproval** – Contact UniCare at 800-442-9300 at least one business day before you order any supplies, such as insulin pumps, if the total cost is expected to be more than $1,000.

✓ **Use preferred vendors** (page 112) – 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.

For a list of UniCare preferred vendors, select *Preferred vendors* on the *Members* page of unicarestateplan.com, or call UniCare Member Services at 833-663-4176 for help.

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.

	Member costs
Dialysis	Deductible

✕ 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. The services must be provided in a hospital, clinic, professional office, home care setting, long-term care setting, or other medical facility.

Member costs		
Office visits		
Primary care visits with a Patient-Centered Primary Care PCP (page 110)	$15 copay	
Other PCP visits	$20 copay	
Specialist visits	$30/60/75 copay	
LiveHealth Online telehealth (page 112)	$15 copay	
	Community Choice	**Non-Community Choice**
Emergency room care	Deductible	Deductible
Inpatient hospital care	Deductible	Deductible
Outpatient hospital care	$30/60/75 copay	$30/60/75 copay

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:

- Telehealth services are covered only when provided by LiveHealth Online. Covered telehealth services are limited to the delivery of services through the use of interactive audio-visual, or other interactive electronic media, for the purpose of diagnosis, consultation, and/or treatment of a patient in a location separate from the provider. There is no coverage for audio-only telephone consultations, email consultations, or services obtained from websites.
- 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.

	Community Choice	Non-Community Choice
Outpatient hospital	Deductible	$50 daily copay and deductible
At a non-hospital-owned lab	Deductible	

✕ 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

	Member costs
☎ ✓ **Breast pumps**	▪ **Preferred vendors:** No member costs ▪ **Non-preferred vendors:** 20% coinsurance
☎ ✓ **Other DME**	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** 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).

■ The Plan will not cover any rental charges that exceed the purchase price of an item.

☎ **BPAP and CPAP equipment need preapproval** – Your doctor must notify AIM Specialty Health at least one business day before you order this equipment.

☎ **Other DME needs preapproval if the total costs will be more than $1,000** – Contact UniCare at 800-442-9300 at least one business day before you order any DME if the total rental or purchase cost is expected to be more than $1,000. However, you don't need preapproval for oxygen or oxygen equipment.

✓ **Use preferred vendors** (page 112) – 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.

For a list of UniCare preferred vendors, select *Preferred vendors* on the *Members* page of unicarestateplan.com, or call UniCare Member Services at 833-663-4176 for help.

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

Early intervention programs

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

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

	Member costs
Early intervention programs	No member costs

Emergency care / urgent care

If you are facing a medical 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 are covered at the same level at both Community Choice and non-Community Choice hospitals.

	Community Choice	Non-Community Choice
At a hospital		
Emergency rooms	$100 copay and deductible (copay is waived if admitted)	$100 copay and deductible (copay is waived if admitted)
At a non-hospital-owned location		
Urgent care centers	$20 copay	
Retail health clinics	$20 copay	
Medical practice office visits	▪ **With a PCP:** $15/20 copay ▪ **With a specialist:** $30/60/75 copay	

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 13.

Table 13. 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, stand-alone 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 the benefits chart shows, how your visit is billed determines how much you owe.

Restrictions:

- 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 radiology benefit (described on page 72) rather than the emergency room benefit.

Notify UniCare if you're admitted to the hospital – If you are admitted to the hospital from the emergency room, you or someone acting for you must notify UniCare at 800-442-9300 within 24 hours of, or the next business day after, being admitted.

Enteral therapy

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

	Member costs
☎ ✓ **Enteral therapy**	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance

☎ **Enteral therapy needs preapproval** – Contact UniCare at 800-442-9300 at least one business day before services start.

✓ **Use preferred vendors** (page 112) – 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.

For a list of UniCare preferred vendors, select *Preferred vendors* on the *Members* page of unicarestateplan.com, or call UniCare Member Services at 833-663-4176 for help.

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.

	Member costs
Routine eye exams Refraction/glaucoma testing	$30/60/75 copay (limited to one exam every 24 months)
Eye care office visits When medically necessary	$30/60/75 copay

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.

	Member costs
Eyeglasses and contact lenses	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.

	Member costs
Family planning services	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 5 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 74-76).

Fitness club reimbursement

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

	Member costs
Fitness club reimbursement	Costs are reimbursed up to $100 for a family each plan year

The fitness reimbursement is paid to the plan enrollee upon proof of payment.

Use the form in Appendix C to submit a request for the fitness reimbursement. You can also download the form from unicarestateplan.com, or call UniCare Member Services at 833-663-4176 to request a copy.

✕ Restrictions:

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

Foot care (routine)

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

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

	Member costs
Routine foot care	▪ **With a PCP:** $15/20 copay ▪ **With a specialist:** $30/60/75 copay

✕ Restrictions:

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

Gynecology exams

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

	Member costs
Annual exam, with Pap smear	No member costs
Office visits	▪ **With a PCP:** $15/20 copay ▪ **With a specialist:** $30/60/75 copay

Hearing aids

Hearing aids are covered when prescribed by a physician.

	Member costs
Age 21 and under	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 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.

	Member costs
Hearing exams	▪ **With a PCP:** $15/20 copay ▪ **With a specialist:** $30/60/75 copay
Hearing screenings for newborns	No member costs

✕ Restrictions:

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

Home health care

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.

	Member costs
☎ ✓ **Home health care**	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance

The following services are covered if they have been preapproved and if they are provided (or supervised) by a health care 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** – Contact UniCare at 800-442-9300 at least one business day before services start.

✓ **Use preferred vendors** (page 112) – 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.

For a list of UniCare preferred vendors, select *Preferred vendors* on the *Members* page of unicarestateplan.com, or call UniCare Member Services at 833-663-4176 for help.

Home infusion therapy

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

	Member costs
✓ **Home infusion therapy**	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance

✕ **Restrictions:**

- Non-oncology infused drugs require prior review and are dispensed by the prescription drug plan (see Part 5 of this handbook).
- You must get subcutaneous and intramuscular drugs through your prescription drug plan.

✓ **Use preferred vendors** (page 112) – 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.

For a list of UniCare preferred vendors, select *Preferred vendors* on the *Members* page of unicarestateplan.com, or call UniCare Member Services at 833-663-4176 for help.

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 68). **Palliative care** is focused on relieving pain or other symptoms of illness and improving the quality of life for patients and their families.

	Member costs
Hospice care	Deductible
Bereavement counseling	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 needed to safely transport you to the place where you will receive a covered hospice care service
- ❑ 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 (see Part 3 of this handbook).
- 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.

Hospital admissions (inpatient)

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).

	Community Choice	Non-Community Choice
At an acute care or rehab hospital		
☎ **Inpatient services (semi-private room)**	$275 quarterly copay and deductible	$750 per-admission copay, deductible, and 20% coinsurance
☎ **Inpatient services (medically necessary private room)**	▪ **First 90 days:** $275 quarterly copay and deductible ▪ **After 90 days:** Dollar difference between the semi-private room rate and the private room rate	▪ **First 90 days:** $750 per-admission copay, 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 (page 64)**	$275 quarterly copay and deductible	▪ **At a designated hospital:** $275 quarterly copay and deductible ▪ **At other hospitals:** $750 per-admission copay, deductible, and 20% coinsurance

	Community Choice	Non-Community Choice
At a skilled nursing facility or long-term care facility		
☎ **Inpatient services**	Deductible and 20% coinsurance (limited to 45 days in a plan year)	

Important! Coinsurance at non-Community Choice hospitals is limited to $5,000 each plan year.

Table 14 lists examples of the services and supplies covered under the benefit for inpatient care.

Table 14. Examples of covered inpatient services

Examples of covered inpatient services and supplies	

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

✕ 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.
- 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.
- The 20% coinsurance for skilled nursing facilities and long-term care facilities does not count toward the non-Community Choice coinsurance limit.

☎ **Notify UniCare about any hospital stay** – You (or someone acting for you) must notify UniCare at 800-442-9300 when you are in the hospital.

- ❑ **Elective admission** – At least seven days in advance
- ❑ **Emergency admission** – Within 24 hours, or the next business day
- ❑ **Maternity admission** – Within 24 hours, or the next business day
- ❑ **Overnight hospital stay** – Within 24 hours, or the next business day
- ❑ **Skilled nursing facility admission** – Within 24 hours, or the next business day

See pages 119-120 for a description of how UniCare reviews inpatient admissions.

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, as well as at Community Choice hospitals, at the Community Choice copay and benefit level:

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

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).

	Member costs
At a doctor's office	No member costs (but you may owe member costs for an office visit)
At a travel clinic	No member costs
At a pharmacy	Covered under your prescription drug plan (pages 147-163)

✕ **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 103.
- The shingles vaccine is only covered for members over the age of 50 (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.
- Storage fees for storing or banking sperm, eggs, and/or inseminated eggs are not covered.
- 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.

Laboratory services (lab work)

Diagnostic lab work is covered when prescribed by a physician.

	Community Choice	Non-Community Choice
At a hospital		
Inpatient	Deductible	Deductible and 20% coinsurance
Outpatient	Deductible	$50 daily copay and deductible
Emergency room	Deductible	Deductible
Preventive lab services	No member costs when done according to the preventive care schedule (Chapter 6)	
At a non-hospital-owned location		
Diagnostic lab work	Deductible, then 100%	
Preventive lab work	No member costs when done according to the preventive care schedule (Chapter 6)	

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 hospital admissions (pages 62-64).

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.

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.

	Member costs
Covered medical services (if not listed elsewhere)	Deductible and 20% coinsurance

Neuropsychological (neuropsych) testing

Neuropsych testing is covered as a medical benefit when the testing is for a condition such as head injury, stroke or dementia and when it is performed by a medical provider. When testing is for a condition like depression and is performed by a behavioral health provider, such as a psychiatrist, it is covered as a behavioral health benefit (see Part 3 of this handbook).

✕ Restrictions:

- 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).

Occupational therapy

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

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

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

	Member costs
☎ **Occupational therapy**	$15 copay

✕ Restrictions:

- Group occupational therapy is not covered.

☎ **Occupational therapy needs preapproval** – Contact UniCare at 800-442-9300 at least one business day before services start.

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.

	Community Choice	Non-Community Choice
Outpatient hospital services (if not listed elsewhere)	Deductible	Deductible

Oxygen

Oxygen and its administration are covered.

	Member costs
✓ **Oxygen**	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** 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 112) – 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.

For a list of UniCare preferred vendors, select *Preferred vendors* on the *Members* page of unicarestateplan.com, or call UniCare Member Services at 833-663-4176 for help.

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 personal emergency response systems (PERS) are covered when:

- ❑ You are housebound
- ❑ You are alone for at least four hours a day, five days a week, and have a physical or mental impairment severe enough to interfere with managing day-to-day tasks
- ❑ A copy of your doctor's letter of medical necessity (documenting that you meet these criteria) is included with the claim

	Member costs
Installation	Deductible and 20% coinsurance (limited to $50 in a plan year)
Rental	Deductible and 20% coinsurance (limited to $40 a month)

✗ Restrictions:

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

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.

	Member costs
☎ **Physical therapy**	$15 copay

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 the treatment of 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.
- Group physical therapy is not covered.
- Services provided by a chiropractor are considered chiropractic care, not physical therapy.
- There is no coverage for any services provided by athletic trainers.
- Massage therapy and services provided by a massage therapist or neuromuscular therapist are not covered.
- There is no coverage for services related to developmental delays that are covered under an early intervention program or under Chapter 766 (or similar laws in other states concerning programs that schools must provide).

☎ **Physical therapy needs preapproval** – Contact UniCare at 800-442-9300 at least one business day before services start.

Prescription drugs

Benefits for most prescription drugs are administered by Express Scripts. See Part 5 (pages 147-163) for benefits information.

☎ **Certain specialty drugs need preapproval** – Some specialty drugs are covered by UniCare and must be preapproved. Your doctor must notify AIM Specialty Health at least seven days before you are scheduled to first get the drug. Go to www.unicarestateplan.com/pdf/SpecialtyDrugList.pdf for a current list of these drugs (the list may change during the year). To learn more about the preapproval process, see pages 32-35.

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.

	Member costs
Preventive care	No member costs

✕ **Restrictions:**

- Not all preventive health care 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.

	Member costs
☎ **Private duty nursing in a home setting**	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 limit) may be 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** – Contact UniCare at 800-442-9300 at least one business day before services start.

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.

	Member costs
Breast prosthetics	Deductible
Orthopedic shoe with attached brace	Deductible
Other prosthetics and orthotics (including mastectomy bras)	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

Radiation therapy

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

	Member costs
☎ **Radiation therapy**	Deductible

☎ **Radiation therapy needs preapproval** – Your doctor must contact AIM Specialty Health at least seven days before services start.

Radiology and imaging services

Radiology services include **high-tech imaging**, which are tests 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 also subject members to significantly higher levels of radiation compared to plain film X-rays and are also much more expensive.

	Community Choice	Non-Community Choice
At a hospital		
Emergency room Including high-tech imaging	Deductible	Deductible
Inpatient Including high-tech imaging	Deductible	Deductible and 20% coinsurance
☎ **Outpatient high-tech imaging** Such as MRIs, CT scans and PET scans	$100 daily copay and deductible	$200 daily copay and deductible
Other outpatient radiology Such as X-rays	Deductible	$50 daily copay and deductible

	Community Choice	Non-Community Choice
At a non-hospital-owned location		
☎ **High-tech imaging** Such as MRIs, CT scans and PET scans	$100 daily copay and deductible	
Other radiology Such as X-rays	Deductible	

☎ **High-tech imaging needs preapproval** – Your doctor must notify AIM Specialty Health at least seven days before any high-tech imaging procedure. However, no notice is needed for any other radiology or imaging services.

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 hospital admissions (pages 62-64).

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 53-54 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 hospital admissions (pages 62-64).

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.

	Community Choice	Non-Community Choice
☎ **Hospital location**	Deductible	$50 daily copay and deductible
☎ **Non-hospital-owned location**	Deductible	

☎ **Sleep studies need preapproval** – Your doctor must notify AIM Specialty Health at least seven days before services start.

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.

	Member costs
Speech therapy	No member costs (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 an autism spectrum disorder
- ❑ Speech rehabilitation, including physiotherapy, following laryngectomy

✕ Restrictions:

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

Surgery

The surgery benefit covers 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.

	Community Choice	Non-Community Choice
☎ Inpatient hospital		
Facility charges	$275 quarterly copay and deductible	$750 per-admission copay, deductible, and 20% coinsurance
Surgeon fees	Deductible	Deductible and 20% coinsurance
☎ Outpatient hospital		
Facility charges and surgeon fees	$110 quarterly copay and deductible	$250 per-visit copay, deductible, and 20% coinsurance
☎ Non-hospital-owned location (such as an ambulatory surgery center)		
Facility charges and surgeon fees	Deductible	

Table 15 lists some of the surgical procedures that are considered surgery and are covered under this benefit.

Table 15. Some example surgical procedures

Examples of procedures covered as surgery	
▪ Cutting procedures ▪ Electrocauterization ▪ Endoscopic procedures ▪ Injection treatment of hemorrhoids and varicose veins ▪ Laser surgery ▪ Radiology procedures requiring intervention ▪ Reduction of a dislocation	▪ Radiation therapy if used instead of a cutting procedure to remove a tumor (does not include radioactive isotope therapy) ▪ Skin tag or wart removal ▪ Suturing of a wound ▪ Treatment of a fracture ▪ Any other procedures classified as surgery by the American Medical Association (AMA)

Reconstructive breast surgery for all stages of mastectomy are covered under this benefit. See page 183 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.

☎ **Some surgeries need preapproval** – Notify UniCare at 800-442-9300 at least seven days before having any of the surgical procedures listed on page 35.

Hip and knee replacement program

UniCare and New England Baptist Hospital have established a program for UniCare 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.

The inpatient hospital copay is waived if you have your surgery at New England Baptist Hospital. In addition, if you use a surgeon who participates in the program, your copays for physical therapy and coinsurance for home health care are also waived.

To learn more about this program or to get a list of participating surgeons, call UniCare Member Services at 833-663-4176.

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.

	Member costs
Tobacco cessation counseling	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 in a face-to-face setting or over the telephone, either individually or in a group.

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

Tobacco cessation counseling can be billed directly to UniCare. However, if your provider is unable to bill the Plan directly, or does not accept insurance, you can submit your claim yourself. Download a claim form at unicarestateplan.com or call UniCare Member Services at 833-663-4176 to ask for one.

Nicotine replacement products are available at no cost through the prescription drug plan, but you must have a prescription. See Part 5 of this handbook for details.

✕ Restrictions:

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

Transplants

Benefits are payable – subject to any deductible, copays, coinsurance and benefit limits – for necessary medical expenses incurred for the transplanting of a human organ. To get the highest benefit, see "Quality Centers and Designated Hospitals for transplants" on page 78.

	Community Choice	Non-Community Choice
☎ **At a Quality Center or Designated Hospital for transplants**	$275 quarterly copay and deductible	$275 quarterly copay and deductible
☎ **At other hospitals**	$275 quarterly copay, deductible, and 20% coinsurance	$750 per-admission copay, deductible, and 20% coinsurance

A UniCare primary nurse is available to support you and your family before the transplant procedure and throughout the recovery period. The primary nurse 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** – Notify UniCare when your doctor recommends a transplant evaluation, but no less than 21 calendar days before transplant-related services are scheduled to start.

- ❑ Call UniCare at 800-442-9300 and ask to speak with a primary nurse. (See pages 134-135 for more information about primary nurses.)
- ❑ You don't need preapproval for cornea transplants.

Human organ donor services

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

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

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

Quality Centers and Designated Hospitals for transplants

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

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

Travel clinics

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

	Member costs
Travel clinic office visits	No member costs
Immunizations at travel clinics	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 103.

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 53-54 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 53-54 for information about the different types of walk-in clinics.

Wigs

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

	Member costs
Wigs	20% coinsurance

✕ Restrictions:

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

Chapter 6: Your benefits for preventive care

The Plan covers preventive or routine office visits, physical exams and other related preventive services listed in Table 16. Covered preventive services include those services recommended by the U.S. Preventive Services Task Force as part of the Patient Protection and Affordable Care Act (PPACA), the health care reform legislation that was passed in March 2010. Preventive exams are covered according to the schedule issued by Massachusetts Health Quality Partners.

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 16. Preventive care schedule

Preventive service	Men	Women	Children	Age	How often / limits
Abdominal aortic aneurysm screening	■	■		65-75	One time
Alcohol misuse screening and counseling	■	■			Part of the preventive exam
Anemia screening		■	■		Part of the preventive exam
Aspirin to prevent cardiovascular disease	■	■			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

Preventive service	Men	Women	Children	Age	How often / limits
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
Colorectal cancer screening – Includes colonoscopies, fecal occult blood testing, and other related services and tests Colonoscopies for members under 50 are covered under limited circumstances (see page 100) ☎ Virtual colonoscopies need preapproval	■	■		50 and older	▪ Every 5 years (60 months) ▪ Every 12 months for fecal occult blood test
Depression screening	■	■	■		Part of the preventive exam
Developmental and behavioral screening			■		Part of the preventive exam
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
Falls prevention – Vitamin D counseling and/or physical therapy for at-risk community-dwelling adults	■	■		65 and over	Counseling is part of the preventive exam
Fluoride supplements – For children, 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 – For newborns			■		At birth
Gonorrhea screening		■			Every 12 months
Gynecological exams		■	■		Every 12 months
Hearing testing – Screening for newborns			■		At birth
Height, weight and body mass index (BMI) measurements	■	■	■		Part of the preventive exam
Hepatitis B screening	■	■	■		
Hepatitis C screening	■	■	■		

Preventive service	Men	Women	Children	Age	How often / limits
HIV screening – For the virus that causes AIDS	■	■	■		
HPV (human papillomavirus) testing – For cervical cancer		■		30 and older	Every 3 years for women with normal cytology results
Hypothyroidism screening – For newborns			■		At birth
Immunizations	■	■	■		
Iron supplements for anemia – For at-risk babies			■	6 to 12 months	
Lab tests – Other covered screening lab tests for adults: ▪ Hemoglobin ▪ Urinalysis ▪ Chemistry profile, including: ▪ Complete blood count (CBC) ▪ Glucose ▪ Blood urea nitrogen (BUN) ▪ Creatinine transferase alanine amino (SGPT) ▪ Transferase asparate amino (SGOT) ▪ Thyroid stimulating hormone (TSH)	■	■			Part of the preventive exam
Lead exposure screening – For children			■		
☎ **Lung cancer scan** – CT lung scan for adults who have smoked	■	■		55-80 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
Pap smears – Screening for cervical cancer		■			Every 12 months
Phenylketonuria (PKU) screening – For newborns			■		At birth
Preeclampsia screening and prevention – During pregnancy		■			Part of the preventive exam

Preventive service	Men	Women	Children	Age	How often / limits
Preventive exams – For 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 exams – For adults age 19 and over	■	■			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 – For newborns			■		At birth
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 track infections (UTI) screening – During pregnancy (asymptomatic bacteriuria)		■			
Vision screening			■		Part of the preventive exam

PART 3:
YOUR BEHAVIORAL HEALTH BENEFITS

Description of coverage for mental health and substance use disorder services

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

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Chapter 7: Using your benefits for behavioral health

Coverage for behavioral health services

UniCare State Indemnity Plan/Community Choice offers comprehensive benefits for behavioral health services. **Behavioral health services** are services that treat mental health and substance use disorder conditions. UniCare has partnered with **Beacon Health Options** to establish a network of experienced behavioral health providers.

Your coverage is highest when you use providers in Beacon's provider network. Your benefits are lower when you get your care from out-of-network providers. In addition, out-of-network providers may balance bill you for the difference between what the Plan paid and what the provider billed.

About behavioral health providers

Through the Beacon network, UniCare offers a broad network of experienced providers, both in and outside of Massachusetts. All of Beacon's in-network providers have met rigorous credentialing standards and are already credentialed as eligible providers.

UniCare will only pay claims from out-of-network providers if the providers are independently licensed in their specialty area, or are working in a facility or licensed clinic under the supervision of an independently-licensed provider. Examples of accepted behavioral health licenses include:

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

Some out-of-network providers may bill you for services instead of submitting claims to UniCare. If this happens, you will need to submit the claims yourself. See page 116 for instructions on how to submit claims to UniCare.

Getting preapproval for behavioral health services

Many behavioral health services require preapproval. Preapproval confirms that the service you're going to have is eligible for benefits. By getting a service preapproved, you reduce your risk of having to pay for a service that isn't covered.

To get assistance with referrals and preapprovals 24 hours a day, seven days a week, call UniCare at 800-442-9300.

Once you get preapproval, you can call the provider of your choice directly to schedule an appointment. If you don't have a provider yet, you can look for an in-network provider from unicarestateplan.com. Go to the *Members* page and choose *Find a behavioral health provider* (under *Quick Links*). You can also call UniCare at 800-442-9300 for help.

If you (or your provider) do not notify UniCare about a service that requires preapproval, your benefits may be reduced or not paid at all.

Table 17. Behavioral health services that need preapproval

Behavioral health service / procedure	In-network providers	Out-of-network providers	See page
Acupuncture withdrawal management (outpatient services)	N/A	Needs preapproval	93
Crisis stabilization units (acute care)	Needs preapproval for stays over 5 days	Needs preapproval for stays over 5 days	88
Day treatment (acute care)	N/A	Needs preapproval	89
Intensive outpatient program (acute care)	Notify UniCare within 48 hours	▪ **DPH-licensed providers in Massachusetts:** Notify UniCare within 48 hours ▪ **All other out-of-network providers:** Needs preapproval	89
Mental health services (acute care) ▪ Acute residential treatment ▪ Community-based acute treatment ▪ Community support programs ▪ Family stabilization teams ▪ Inpatient psychiatric services ▪ Partial hospitalization programs ▪ Transitional care units	Needs preapproval	Needs preapproval	88

Behavioral health service / procedure	In-network providers	Out-of-network providers	See page
Outpatient services ▪ Applied Behavioral Analysis ▪ Dialectical behavioral therapy ▪ Electroconvulsive therapy ▪ Neuropsychological testing ▪ Psychiatric visiting nurse services ▪ Psychological testing ▪ Transcranial magnetic stimulation	Needs preapproval	Needs preapproval	93
Structured outpatient addictions programs (acute care)	Notify UniCare within 48 hours	▪ **DPH-licensed providers in Massachusetts:** Notify UniCare within 48 hours ▪ **All other out-of-network providers:** Needs preapproval	89
Substance use disorder services – Adults and adolescents (acute care) ▪ Acute residential withdrawal management (ASAM level 3.7 detox) ▪ Clinical stabilization services for substance use disorder (ASAM level 3.5) ▪ Dual diagnosis acute treatment (ASAM level 3.5) ▪ Medically-managed substance use disorder services (ASAM level 4 detox) ▪ Partial hospitalization program for substance use disorder (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 out-of-network providers:** Needs preapproval	88
Telehealth with LiveHealth Online (mental health) *You don't need preapproval for telehealth to treat substance use disorders*	Needs preapproval for more than 26 visits in a plan year	N/A	94
Therapy – Family and individual (mental health) *You don't need preapproval for therapy to treat substance use disorders*	Needs preapproval for more than 26 visits in a plan year	Needs preapproval for more than 26 visits in a plan year	95

Chapter 8: Summary of your costs for behavioral health services

For a description of the symbols that appear in this table, see page 16.

Table 18. Summary of covered behavioral health services

Service	Member costs with in-network providers	Member costs with out-of-network providers	See page
☎ **Acute care services**	$200 quarterly copay	$200 quarterly copay and deductible	88
Emergency care			91
▪ Hospital emergency room	Covered as a medical benefit (pages 53-54)	Covered as a medical benefit (pages 53-54)	
▪ Emergency services programs	No member costs	No member costs	
LiveHealth Online telehealth	$15 copay	*Not applicable*	94
Medication management (outpatient)	$15 copay	$30 copay and deductible	92
Methadone maintenance	No member costs	No member costs	92
☎ **Outpatient services**	$20 copay	$30 copay and deductible	93
Substance use disorder assessment/referral	No member costs	No member costs	94
Therapy (outpatient)			95
▪ Family therapy	$20 copay	$30 copay and deductible	
▪ Group therapy	$15 copay	$30 copay and deductible	
▪ Individual therapy	$20 copay	$30 copay and deductible	

To be covered, services must be medically necessary.
Benefits are limited to the Plan's allowed amounts for the services (page 29).

Chapter 9: Covered behavioral health services

Acute care (inpatient and outpatient)

The Plan covers both inpatient and outpatient acute care services to treat a mental health or substance use disorder condition. **Acute care** addresses behavioral health conditions with severe symptoms that are expected to improve with intensive, short-term treatment. Most acute care services are available for both adults and adolescents, unless otherwise noted.

	Member costs with in-network providers	Member costs with out-of-network providers
☎ **Acute care services**	$200 quarterly copay	$200 quarterly copay and deductible

Inpatient acute care

Inpatient acute care refers to behavioral health treatment you get when staying overnight (that is, you are an inpatient) at an acute care hospital, psychiatric hospital, substance use disorder facility, or residential facility. Inpatient acute care includes the following types of services and programs:

- **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 (CSS) for substance use disorder (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 unit (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
- **Medically-managed substance use disorder services (ASAM level 4 detox)** – 24-hour medical care for substance withdrawal provided at an acute care hospital

- ❑ **Observation stay** – 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

Outpatient acute care

Outpatient acute care includes services that don't require an overnight stay but that do require more intensive support than other kinds of outpatient care. Outpatient acute care includes the following types of services and programs:

- ❑ **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
- ❑ **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 for mental health / intensive outpatient programs 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 for mental health / partial hospitalization programs 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.
- ❑ **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:

- **Inpatient services** – If you are admitted to an out-of-network hospital from the emergency room and there are no in-network providers available, you'll owe only the in-network quarterly copay.

☎ Acute care services may need preapproval – You (or someone acting for you) may need to notify UniCare at 800-442-9300 when you get behavioral health acute care services (see the table on pages 85-86).

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

Emergency care

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. If you call UniCare seeking non-life threatening emergency care, UniCare will connect you with appropriate services within six hours.

	Member costs with in-network providers	Member costs with out-of-network providers
Hospital emergency room	Covered as a medical benefit (pages 53-54)	Covered as a medical benefit (pages 53-54)
Emergency service programs in Massachusetts	No member costs	No member costs

Urgent care refers to services you get when your health is not in serious danger but you need care right away. You should 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 in-network 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.

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 are admitted to an out-of-network hospital from the emergency room and there are no in-network providers available, you'll owe only the in-network quarterly copay.
- UniCare will pay up to the out-of-network allowed amount for services you get at an out-of-network inpatient facility. You may be responsible for paying charges over the allowed amount (that is, the facility may balance bill you).

☎ **Notify UniCare if you're admitted to the hospital** – If you are admitted to the hospital from the emergency room, you or someone acting for you must notify UniCare at 800-442-9300 within 24 hours of being admitted.

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 during a telehealth visit.

	Member costs with in-network providers	Member costs with out-of-network providers
Medication management	$15 copay	$30 copay and deductible
Telehealth medication management	$15 copay	*Not applicable*

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.

☎ **You need preapproval for more than 26 therapy sessions** – You must get preapproval if you have more than 26 therapy sessions within a single plan year. Medication management visits that include therapy count toward this requirement, as do individual, family, and telehealth therapy sessions. You don't need preapproval for therapy to treat substance use disorder or for medication management visits that don't include therapy.

Methadone maintenance

Methadone maintenance is the long-term prescribing of methadone as an alternative to the opioid on which a member was dependent. Typically, the member goes to a clinic daily to get the methadone.

	Member costs with in-network providers	Member costs with out-of-network providers
Methadone maintenance	No member costs	No member costs

Outpatient services

The Plan covers medically necessary outpatient behavioral health services to treat mental health and substance use disorder conditions.

	Member costs with in-network providers	Member costs with out-of-network providers
☎ **Outpatient services**	$20 copay	$30 copay and deductible

Covered outpatient services include the following types of services and programs:

- ❑ **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.
- ❑ **Electroconvulsive therapy (ECT)** – Psychiatric treatment in which seizures are electrically induced in patients to provide relief from mental 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 outpatient 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.
- Neuropsych testing for medical conditions is covered as a medical benefit, not as a behavioral health benefit.

☎ Outpatient services may need preapproval – You may need to contact UniCare at 800-442-9300 if you will be having outpatient services (see the table on pages 85-86).

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.

	Member costs with in-network providers	Member costs with out-of-network providers
Substance use disorder assessment / referral	No member costs	No member costs

Telehealth services

The Plan covers video-based counseling and video-based medication management sessions when provided by LiveHealth Online.

	Member costs with in-network providers	Member costs with out-of-network providers
LiveHealth Online telehealth (therapy)	$15 copay	*Not applicable*
LiveHealth Online telehealth (medication management)	$15 copay	*Not applicable*

LiveHealth® Online is a service that lets you talk face-to-face to a doctor through your smartphone, tablet or computer with internet access and a camera. Doctors are available 24 hours a day, 365 days a year. LiveHealth Online is currently the only approved telehealth program for UniCare members.

Go to livehealthonline.com to learn more and to download the free app.

Restrictions:

- Covered telehealth services are limited to the delivery of services through the use of interactive audio-visual, or other interactive electronic media, for the purpose of diagnosis, consultation, and/or treatment of a patient in a location separate from the provider. There is no coverage for audio-only telephone consultations, email consultations, or services obtained from websites.
- There is no coverage for telehealth services from out-of-network providers.
- Telehealth providers must be licensed in the state where you get the services.

You need preapproval for more than 26 therapy sessions – You must get preapproval if you have more than 26 therapy sessions within a single plan year. The 26-session preapproval requirement includes all individual, family, and telehealth therapy sessions. Medication management visits that include therapy also count toward this requirement, but medication management visits alone do not. You also don't need preapproval for therapy to treat substance use disorder.

Therapy (outpatient)

The Plan covers medically necessary individual, family, and group therapy. Medication management performed in combination with therapy is also covered.

	Member costs with in-network providers	Member costs with out-of-network providers
Family therapy	$20 copay	$30 copay and deductible
Group therapy	$15 copay	$30 copay and deductible
Individual therapy	$20 copay	$30 copay and 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.

☎ You need preapproval for more than 26 therapy sessions – You must get preapproval if you have more than 26 therapy sessions within a single plan year. The 26-session preapproval requirement includes all individual, family, and telehealth therapy sessions. Medication management visits that include therapy also count toward this requirement, but medication management visits alone do not. You also don't need preapproval for therapy to treat substance use disorder.

PART 4:
USING YOUR PLAN

Plan and coverage details

For questions about any of the information in Part 4 of this handbook, please call UniCare Member Services at 833-663-4176.

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Chapter 10: 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 19. Excluded, restricted and limited benefits

Service	What is not covered or has limited coverage
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: ▪ Transfers by ambulance are only covered if you are in a facility that cannot treat your condition, and only to the nearest facility that can provide 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 a medical emergency. ▪ Transportation in chair cars or vans is not covered. ▪ There is no coverage for charges when ambulance calls are refused. ▪ Transfers between facilities for behavioral health services are covered if the Plan has requested and arranged for it.
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
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
Blood	The Plan does not pay for donated blood
Blood pressure cuffs (sphygmomanometers)	Not covered
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
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 45-46)

Service	What is not covered or has limited coverage
Cognitive rehabilitation therapy	Not covered **Cognitive rehabilitation therapy** 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 50	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.
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 (pages 46-47).
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 5 of this handbook).
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.

Service	What is not covered or has limited coverage
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 5 of this handbook).
Drugs – Specialty	Some specialty drugs are covered by the Plan and must be preapproved. Go to www.unicarestateplan.com/pdf/SpecialtyDrugList.pdf for a current list of these drugs (the list may change during the year). The preapproval process is described on pages 32-35. Other self- or office-administered specialty drugs are dispensed under the prescription drug plan (Part 5 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
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
Email consultations	Not covered (also see **Telehealth**)

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
Facility fees	No coverage for facility fees for outpatient behavioral health 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) ▪ Membership and joining fees (e.g., Weight Watchers), with the exception of the fitness club 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. ▪ Fitness clubs are limited to health clubs or gyms that offer cardio and strength-training machines, and other programs for improved physical fitness. ▪ Martial arts centers, gymnastics centers, country clubs, beach clubs, sports teams and leagues, tennis clubs, and dance classes/studios are not considered fitness clubs. ▪ Athletic trainers, sports coaches, yoga classes and exercise machines are not covered.
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
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 chiropractic care, group occupational therapy, and group physical therapy	Not covered
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
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 not covered. ▪ 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.
Language therapy for learning disabilities	Not covered
Lift / riser chairs	Not covered
Light boxes	Covered only for treatment of skin conditions
Long-term maintenance care and long-term therapy	Not covered
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.
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 60-61)
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.

Service	What is not covered or has limited coverage
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
Narconon treatment and facilities	Not covered
Neuropsych testing for ADHD	No coverage for neuropsych testing to diagnose attention-deficit hyperactivity disorder (ADHD)
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
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 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 44) ▪ Members with certain eating disorders ▪ Members with diabetes (page 47)

Service	What is not covered or has limited coverage
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
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
Park admissions	No coverage for admissions fees to national parks or preserves
Pastoral counselors	Covered for bereavement counseling, or when required by law
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 ▪ Services provided by a chiropractor are considered chiropractic care, not 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
Reiki therapy	Not covered **Reiki** is a hands-on energy-based therapy.
Religious facilities	No coverage for services received at non-medical religious facilities

Service	What is not covered or has limited coverage
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)
Schools	No coverage for any services required under law to be provided by the school system for a child
Sensory integration therapy	Not covered
Serious preventable adverse events	Costs associated with serious preventable adverse health care events are not covered, in accordance with Department of Public Health (DPH) regulations. Massachusetts providers are not permitted to bill members for designated serious reportable health care events. See unicarestateplan.com for more information about this policy.
Shingles vaccine	Covered only for members over age 50
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

Service	What is not covered or has limited coverage
Telehealth	Coverage is provided for LiveHealth Online only. There is no coverage for: ▪ Audio-only telephone consultations ▪ Email consultations ▪ Services obtained from websites ▪ Services provided using non-HIPAA compliant technology (e.g., Skype or telephone) ▪ Charges for technology or equipment needed to provide HIPAA-compliant services ▪ Services from a provider who is not licensed in the state where you get the service
Telephone consultations	Not covered (also see **Telehealth**)
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 hot or cold thermal therapy device
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.
Tobacco cessation counseling	Limited to 300 minutes each plan year. Counseling is also covered as part of your preventive exam.
Transportation to medical appointments	Not covered
Travel time	No coverage for travel time to or from medical appointments
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
Web-based services	No coverage for consultations or services from websites except through LiveHealth Online (also see **Telehealth**)

Service	What is not covered or has limited coverage
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-ray equipment (portable)	No coverage for costs associated with transporting and setting up portable X-ray equipment.

Chapter 11: About your plan and coverage

Types of health care providers

What is a health care provider? A health care provider is a person, place, or organization that delivers medical 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.

To find health care providers, choose the *Find a doctor* button at the top of the *Members* page at unicarestateplan.com, or call UniCare Member Services at 833-663-4176 for help.

Primary care providers (PCPs)

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

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

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

Patient-Centered Primary Care practices

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

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

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

As a Community Choice member, your primary care office visit copay is lowest when you select a PCP who belongs to a Patient-Centered Primary Care practice.

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

Specialists

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

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

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.

Behavioral health providers who belong to the Beacon Health Options network are covered at a higher benefit level than providers who don't belong to the Beacon network. For more information about behavioral health providers and the Beacon provider network, see page 84.

Hospitals and other inpatient facilities

The Plan covers hospital services when you are admitted to an inpatient facility. Your benefits for these services depends on what type of inpatient facility you go to and the type of care you get. See pages 62-64 for coverage details.

- **Acute care hospitals** are 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** 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. The Plan does not cover custodial care.

Walk-in clinics

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, stand-alone 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 are. 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. How your visit is billed determines how much you owe. See pages 53-54 for coverage details.

Telehealth services through LiveHealth Online

LiveHealth® Online is a 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 is currently the only approved telehealth program for UniCare members.

Go to livehealthonline.com to learn more and to download the free app.

Preferred vendors

Preferred vendors 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.

For a list of UniCare preferred vendors, select *Preferred vendors* on the *Members* page of unicarestateplan.com, or call UniCare Member Services at 833-663-4176 for help.

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, stand-alone centers that provide a variety of medical services. They include:

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

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

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

Contracted providers

Contracted providers are non-Massachusetts providers of medical care and services – 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 provider because state law prohibits Massachusetts medical providers from balance billing UniCare members.

Behavioral health services – For mental health and substance use disorder services, you must use a provider in the Beacon Health Options network to avoid getting balance billed. See Part 3 (pages 83-95) for information about these benefits.

How to find providers

To find health care providers, select *Look for health care providers* on the *Members* page at unicarestateplan.com. You'll find options that let you search for:

- Doctors and hospitals in Massachusetts
- Contracted providers outside of Massachusetts
- PCPs participating in the Patient-Centered Primary Care program
- Urgent care centers
- Retail health clinics
- Preferred vendors
- Specialized health facilities
- Behavioral health providers in the Beacon Health Options network

You can also call UniCare Member Services at 833-663-4176 for help.

About physician tiering

Physician tiering is a program implemented by the Plan whereby Massachusetts specialists are assigned to different tiers based on an extensive evaluation of both their quality and cost efficiency.

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

***Tier 1 (Excellent)

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

**Tier 2 (Good)

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

*Tier 3 (Standard)

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

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

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

Primary care providers (PCPs) are included in our physician listing, but they aren't tiered. You pay a $15 copay for primary care visits with PCPs who belong to a UniCare Patient-Centered Primary Care practice and a $20 copay for other primary care visits. PCPs include physicians, nurse practitioners and physician assistants whose specialty is family medicine, general medicine, pediatrics, geriatrics or internal medicine.

You can find a detailed explanation about the assignment of doctors to tiers and about the methods used to determine the quality and cost-efficiency scores of the physicians at unicarestateplan.com. You can also call UniCare Member Services at 833-663-4176 to request materials.

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

How to find a specialist's tier

To find out which tier a specialist is in, select *Find a doctor* on the *Members* page at unicarestateplan.com. You can also call UniCare Member Services at 833-663-4176 for help.

How UniCare reimburses providers

The Plan routinely reimburses providers on a fee-for-service basis. As various models of health care reform are put in place, as anticipated by legislation in Massachusetts, the Plan may engage certain providers in shared savings and loss arrangements where providers receive additional payments for meeting quality and cost targets. 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 health care providers will submit claims for you. If your provider files claims on your behalf, the provider will be paid directly.

If you submit your own claim, you must provide written proof of the claim that includes:

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

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

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

You can print or request a claim form from unicarestateplan.com, or call UniCare Member Services at 833-663-4176 to request a form.

Claims for prescription drug services – These claims must be submitted directly to the administrator of those services. See Part 5 of this handbook (pages 147-163).

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

You can also download this form from unicarestateplan.com.

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 must be approved by the Executive Director of the GIC, and will be performed at no expense to you.

Deadlines on bringing legal action

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

Right of reimbursement (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.

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 for preapprovals

UniCare reviews certain medical services and inpatient admissions to make sure they are eligible for benefits.

- ❑ Preapprovals for medical services are discussed on pages 32-35.
- ❑ Preapprovals for behavioral health services are discussed on pages 85-86.

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.

If you call after business hours, you can leave a message. Member Services will return your call on the next business day. UniCare staff will identify themselves by name, title and organization when they call.

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.

When you first ask for preapproval

When you (or someone acting for you) notifies UniCare 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 5 of this handbook (pages 147-163).

Chapter 12: 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, "Federal and State Mandates."

Application for coverage

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

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

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

- **Newborns:** copy of hospital announcement letter or the child's certified birth certificate
- **Adopted children:** photocopy of proof of placement letter, 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 disabled by age 19, marries
6. The date the covered divorced spouse remarries (or the date the enrollee marries)
7. The date of the spouse or dependent's death, or
8. The date the Plan terminates

Duplicate coverage

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

Special enrollment condition

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

Continuing coverage upon termination of employment

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

Continuing health coverage for survivors

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

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

Coverage will end on the earliest of:

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

Option to continue coverage for dependents age 26 and over

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

Option to continue coverage after a change in marital status

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

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

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

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

Group health continuation coverage under COBRA

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

You must complete 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 8747, Boston, MA 02114 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 coverage?

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

Who is eligible for COBRA coverage?

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

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

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

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

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

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

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

How long does COBRA coverage last?

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

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

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

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

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

How and when do I elect COBRA coverage?

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

In considering whether to elect COBRA 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 coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA coverage cost?

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

How and when do I pay for COBRA coverage?

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

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

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

Can I elect other health coverage besides COBRA?

Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. Alternately, if you are a Massachusetts resident, you may purchase health insurance through the Massachusetts Health Connector, 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 coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

Your COBRA coverage responsibilities

- **You must inform the GIC of any address changes to preserve your COBRA rights;**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above.** If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill.** If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.

- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
  - The employee's job terminates or his/her hours are reduced;
  - The insured dies;
  - The insured becomes legally separated or divorced;
  - The insured or insured's former spouse remarries;
  - A covered child ceases to be a dependent under GIC eligibility rules;
  - The Social Security Administration determines that the employee or a covered family member is disabled; or
  - The Social Security Administration determines that the employee or a covered family member is no longer disabled.

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

If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617-727-2310 or write to the GIC at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration 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 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 health care plan. This happens, for example, when spouses or partners have family coverage through both of their employers or former employers. When you or your dependents are covered by more than one health plan, one plan is identified as the primary plan for coordination of benefits (COB). Any other plan is then the secondary plan. The goal of COB is to determine how much each plan should pay when you have a claim, and to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Definition of plan

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

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

Determining the order of coverage

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

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

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

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

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

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

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

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

   If there is no such decree determining which parent is financially responsible for the child's health care expenses, coverage is determined as follows:
   a) First, the plan covering the parent with custody of the child (the custodial parent)
   b) Second, the plan covering the custodial parent's spouse, if applicable
   c) Third, the plan covering the non-custodial parent
   d) Fourth, the plan covering the non-custodial parent's spouse, if applicable
5. According to the **active before retiree rule**, the plan that covers a person as an active employee is primary, and the plan that covers that same person as a retiree is secondary. This applies both to that person and his or her dependents.

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

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

Right to receive and release information

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

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

Facility of payment

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

Right of recovery

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

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

COB for persons enrolled in Medicare

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

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

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

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

Medical coverage primary to Medicare coverage for the disabled

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

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

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

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

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**.

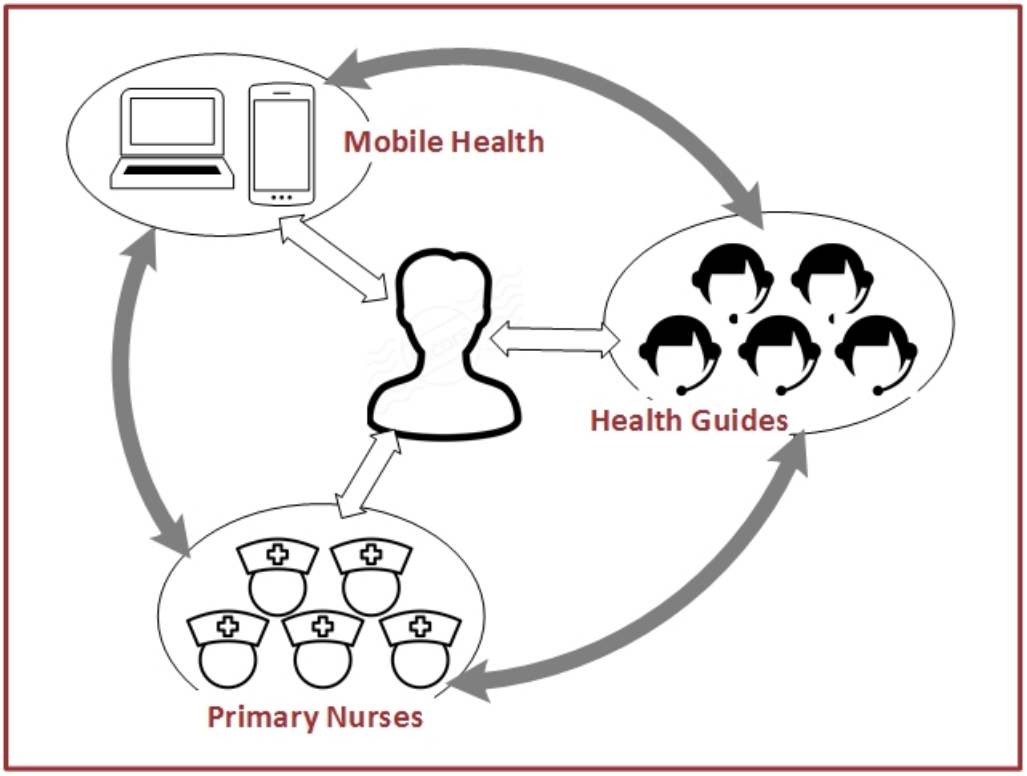
During that 30-month period, the UniCare State Indemnity Plan is the primary payer and Medicare is the secondary payer for the purpose of the coordination of benefits (COB). After the 30 months, Medicare becomes the primary payer and the Plan becomes the secondary payer. At this point, you must change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

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

Chapter 13: How to find out more

Getting help from UniCare Member Services

UniCare Member Services combines specially-trained people and supporting technology that work together to offer you more personal service and an improved member experience. Because the different components of Member Services can quickly and easily share information with you and with each other, they can offer more personal and thorough responses to your questions and concerns.



Member Services includes the following three components:

- **UniCare health guides** are specially trained representatives who take members' calls and answer questions. See page 134 for a description of how health guides can help you.
- **UniCare primary nurses** work one-on-one with members and their families to address personal health care goals and issues, like chronic health conditions and healthy living goals. See pages 134-135 to find out more about the types of support primary nurses can provide.
- **Mobile Health** gives you electronic access to plan information and UniCare Member Services from your mobile device or computer. See page 135 to learn how to get started with Mobile Health.

How to reach UniCare Member Services

	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 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

UniCare Primary Nurses: When you need support

UniCare primary nurses work one-on-one with members and their families to address health care related issues. Once you connect with your primary nurse, he or she will continue to be the personal health consultant for you and your family – someone you can contact directly.

Your primary nurse may also reach out to bring health issues to your attention, or to offer assistance should a health concern arise. Whatever your question or concern, you can reach out to your primary nurse for help.

Your primary nurse can help you…	
▪ Get answers to questions about you and your family's health care needs ▪ Determine how to best use your benefits ▪ Get advice from specialized health professionals including 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

Your UniCare primary nurse is an especially important resource when you are dealing with a major health issue – whether you have an ongoing condition like diabetes, or an urgent situation that arises unexpectedly, like a stroke or cancer diagnosis.

Major health issues require multiple medical services which can be hard to navigate. In addition, such issues often have an impact – directly or indirectly – on other family members.

In this kind of situation, your primary nurse is available to support all family members, and to offer help and advice on how to effectively manage your health care needs.

When you face a major health issue, your primary nurse 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 health care planning ▪ Work with your doctors to support your present and future health care 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

About Mobile Health

Mobile Health gives you electronic access to plan information and member services from your mobile device or computer. Once you've registered with Mobile Health and completed your initial health assessment, Mobile Health has tools that let you track not just your claims but your overall health and medical situation.

Use Mobile Health to…	
▪ Get information about your plan benefits ▪ Check on the status of your claims ▪ Look for doctors, hospitals and other health providers ▪ Track your biometric levels, such as body mass index (BMI), blood pressure and cholesterol ▪ 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 ▪ View your member ID card ▪ Get digital reminders about scheduling checkups and important tests

Getting started with Mobile Health

From a smartphone or other mobile device	1. Go to the App Store® or Google Play® 2. Search for **Mobile Health Consumer**
From a computer	1. Go to mobilehealthconsumer.com 2. Select the **User** button in the top-right corner

Completing your health assessment

Your personal **health assessment** provides the "baseline" information that allows UniCare health guides and primary nurses to deliver personalized member services. Select **Health Assessment** to get started.

Using the unicarestateplan.com website

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

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

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

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

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

Set up a user account

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

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

Find providers

Select *Look for health care providers* on the *Members* page at unicarestateplan.com. You'll find a variety of options that let you search for:

- Doctors and hospitals in Massachusetts
- Contracted providers outside of Massachusetts
- PCPs participating in the Patient-Centered Primary Care program
- Preferred vendors
- Urgent care centers
- Retail health clinics
- Specialized health facilities
- Behavioral health providers in the Beacon Health Options network

Compare costs and earn cash rewards at Massachusetts facilities

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

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

Using SmartShopper does not change your plan benefits or your member costs (copays, deductible and coinsurance). Be sure to select a Community Choice hospital to get the best benefit.

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

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

Get documents, forms and other materials

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

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

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

Using the 24/7 NurseLine

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

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

To speak with a nurse, call the 24/7 NurseLine toll free at 800-424-8814 and, when prompted, be sure to choose the NurseLine 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 check on your claims

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

- Call 833-663-4176 and select the option to access our automated information line.
- Go to unicarestateplan.com and set up a user account (page 136).

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. You can download this form from unicarestateplan.com, or call UniCare Member Services at 833-663-4176 to ask to have the form sent to you.

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 14: Plan definitions

Term	What it means
Acupuncture withdrawal management (detox)	The use of acupuncture to ease the symptoms of drug or alcohol withdrawal.
Acute care services	See **Behavioral health acute care services**
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 *(see 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, health care 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 pre-existing condition exclusion, 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 copayments ▪ A rescission of coverage (a retroactive cancellation), except if it results from failure to pay premiums
Allowed amount *(see page 29)*	The maximum amount on which payment is based for covered health care services. If a non-Massachusetts provider charges more than the allowed amount, you may have to pay the difference. (Also see **Balance billing**.)
Ambulatory surgery center	An independent, stand-alone facility licensed to provide same-day 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 *(see 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
Balance billing *(see page 29)*	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 acute care services	Treatment for behavioral health conditions that have severe symptoms but that are expected to improve with intensive, short-term treatment.
Behavioral health services *(see pages 83-95)*	Services to treat mental health and substance use disorder conditions. The benefits for these services are described in Part 3 of this handbook.
Clinical stabilization services (CSS)	Clinically managed detox and recovery services provided in a non-medical setting.
Coinsurance *(see page 27)*	Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance *plus* any copays and deductible that may apply.
Community-based acute treatment (CBAT)	Treatment for children and adolescents with serious behavioral health disorders who need a protected and structured environment.
Community Choice hospital	A Massachusetts hospital where you have lower member copays and no coinsurance for certain services, including inpatient admissions and outpatient surgery. Community Choice hospitals are listed in Appendix B.
Community support programs (CSP)	Programs to help members access and use behavioral health services.
Copay (copayment) *(see pages 22-27)*	A fixed amount you pay for a covered health care service, usually when you get the service. The dollar amount of the copay depends on the service it applies to. Not all services have copays.
Cosmetic services *(see page 100)*	Services performed mainly to improve appearance. These services do not restore bodily function or correct functional impairment. Cosmetic services are not covered.
Crisis stabilization unit (CSU)	24-hour observation and supervision for behavioral health conditions when inpatient care isn't needed.
Custodial care *(see page 63)*	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.
Day treatment	Behavioral health programs offering structured, goal-oriented treatment that focuses on improving one's ability to function in the community.
Deductible *(see page 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. The deductible doesn't apply to all services.

Term	What it means
Dependent *(see Chapter 12)*	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.
Dual diagnosis acute treatment (DDAT)	Clinically-managed detox and recovery services for those with both a substance abuse and mental health condition who require a protected and structured environment.
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.
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.)
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.
Family stabilization team (FST)	Programs offering intensive services in the home to help children, adolescents and their families deal with complex life stressors.
Grievance	A complaint that you communicate to the Plan.
Home state	The state where you live and get your routine health care.

Term	What it means
Hospital / acute care hospital *(see pages 62-64)*	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 (Also see **Community Choice hospital**)
Injury	Accidental bodily harm caused by something external (outside of your body).
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.
Long-term care facilities *(see pages 62-64)*	Specialized hospitals that treat patients who need further care for complex medical conditions but no longer require the services of a traditional hospital.
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 supplies or equipment	Disposable items that physicians prescribe as medically necessary to treat a disease or injury. Such items include surgical dressings, splints and braces.
Medically necessary	With respect to care under the Plan, medically necessary treatment will meet at least the following standards: 1. Is adequate and essential for evaluation or treatment consistent with the symptoms, proper diagnosis and treatment appropriate for your illness, disease or condition as defined by standard diagnostic nomenclatures (DSM-V or its equivalent ICD-10CM) 2. Is reasonably expected to improve or palliate your illness, condition or level of functioning 3. Is safe and effective according to nationally-accepted standard clinical evidence that is generally recognized by medical professionals and peer-reviewed publications 4. Is the most appropriate and cost-effective level of care that can safely be provided for your diagnosed condition 5. Is based on scientific evidence for services and interventions that are not in widespread use **Important!** The fact that a doctor may prescribe, order, recommend or approve a procedure, treatment, facility, supply, device or drug does not, in and of itself, make it medically necessary or make the charge a covered expense under the Plan, even if it has not been listed as an exclusion.

Term	What it means
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	Costs that you pay yourself toward your medical bills: deductible, copays and coinsurance. Member costs are also known as **out-of-pocket costs**.
Methadone maintenance	Long-term prescribing of methadone as an alternative to the opioid on which a member was dependent. Typically, a member goes to a clinic daily to get the methadone.
Network	The facilities, providers and suppliers that the Plan has contracted with to provide health care services.
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-Community Choice coinsurance limit *(page 27)*	A cap on how much coinsurance you could pay during a plan year for services at non-Community Choice hospitals. Copays for care at non-Community Choice hospitals ***are not*** included in this limit. (Also see **Out-of-pocket maximum**)
Non-preferred vendor *(see page 112)*	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.
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.
Out-of-pocket maximum *(see page 27)*	The most you could pay during the plan year for your member costs (deductible, copays, coinsurance) for covered services. Once you reach your out-of-pocket maximum, the Plan starts to pay 100% of the allowed amount. Community Choice has three separate maximums that apply to different services: ▪ Out-of-pocket maximum on costs for medical services at Community Choice hospitals, non-hospital medical services, prescription drugs, and in-network behavioral health services ▪ Out-of-pocket maximum on out-of-network behavioral health costs ▪ Limit on your coinsurance at non-Community Choice hospitals. Out-of-pocket maximums never include premiums, balance-billed charges, or costs for services that the Plan doesn't cover.
Partial hospitalization programs (PHP)	Non-residential, structured outpatient psychiatric and substance abuse 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 health care providers acting within the scope of their licenses or certifications: ▪ Certified nurse midwife ▪ Chiropractor ▪ Dentist ▪ Nurse practitioner ▪ Optometrist ▪ Physician ▪ Physician assistant ▪ Podiatrist See page 84 for a list of types of behavioral health providers.
Preapproval	Review process to confirm that a service you're going to have is eligible for benefits. Preapproval review reduces your risk of having to pay for a service that isn't covered.
Preferred vendors *(see page 112)*	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.
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.
Rehabilitation (rehab) facilities *(see pages 62-64)*	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	Health care services that help a person keep, get back or improve skills and functioning for daily living that were lost or impaired due to illness, injury or disability. These services may include physical therapy, occupational therapy, and speech-language pathology in a variety of inpatient and/or outpatient settings.
Retail health clinic *(see page 112)*	Walk-in clinics located in retail stores or pharmacies. They offer basic services like vaccinations and treatment for colds or mild sinus infections.
Skilled care	Medical services that can only be provided by a registered or certified professional health care provider.

Term	What it means
Skilled nursing facility *(see pages 62-64)*	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)
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	A comprehensive assessment of substance use to allow a provider to refer a member to appropriate care.
Tiers *(see page 114)*	Different levels that the Plan groups specialists and hospitals into, based upon an evaluation of certain quality and cost-efficiency measures.
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.
Urgent care center *(see page 112)*	An independent, stand-alone 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.
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.

PART 5:
YOUR PRESCRIPTION DRUG BENEFITS

Description of coverage for prescription drugs

For questions about any of the information in Part 5 of this handbook, please call Express Scripts at 855-283-7679.

Administered by

EXPRESS SCRIPTS®

Chapter 15: Your prescription drug plan

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 154 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).

Copayments and Deductible

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

Table 20. Deductible for prescription drugs

Deductible (fiscal year July through June)	
For an individual	**$100 for one person**
For a family	**$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 21. Copayments for prescription drugs

Copayment 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 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 Deductible does not apply	$0 Deductible does not apply

Copayment 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.

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 copayments 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 22. 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 booklet that includes a prescription drug benefit overview, drug list and a mail order claim form.

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

Register 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 Prescriptions

You may fill your prescriptions for non-specialty drugs at any participating retail pharmacy, or through mail order from the Express Scripts Pharmacy[SM]. 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 copayment. Prescriptions filled at a non-participating retail pharmacy are not covered.

You can locate the nearest participating retail pharmacy anytime online after registering at 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.

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 copayment, 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 copayment 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 copayments. 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 copayment 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 877-895-9697.

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 23. 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 copayment. -or- Claims incurred more than 30 days after the member's eligibility effective date will be reimbursed at a discounted cost, less the applicable copayment.
Claim forms are available to registered users on 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 and brand (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
Folic acid supplements	Generic OTC and Rx versions (0.4mg – 0.8mg strengths only) when prescribed for women under the age of 51
Immunization vaccines	Generic or brand versions prescribed for children or adults
Oral fluoride supplements	Generic and brand supplements prescribed for children 6 months through five 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
Vitamin D supplements	Generic OTC and Rx vitamin D products for adults ≥ 65 years old
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 copayment will not apply. Instead, you will be responsible for the full difference in price between the brand-name drug and the generic drug, plus the generic copayment. This amount does not count towards the out-of-pocket 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. Your plan does not provide benefits for prescription drugs when OTC equivalents are available. This provision is not applicable to preventive drugs.

Prior Authorization

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

If a drug that you take requires prior authorization, your physician will need to contact 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 24. Current examples of drugs requiring prior authorization for specific conditions[1]

Drug Class	Products Requiring Prior Authorization (PA)
Acne	Tazorac®/Fabior®
	Topical tretinoin products (Retin-A®, Retin-A Micro® – Ortho; Avita® – Bertek Pharmaceuticals; Tretin·X™ – Triax; Atralin™ gel – Coria; other generic – various manufacturers) and clindamycin phosphate 1.2% and tretinoin 0.025% gel, Ziana® – Medicis; Veltin® – Stiefel. *PA required only in adults age 36 and older.*
	Topical tazarotene products *(Tazorac® 0.05% and 0.1% cream, gel – Allergan; Fabior® 0.1% foam – Stiefel)*
Testosterone	(Aveed®, Depo®-Testosterone [testosterone cypionate injection, generics], Delatestryl® [testosterone enanthate injection, generics], Testopel® [testosterone pellet])
	(Androderm®, AndroGel®, Axiron®, Fortesta®, Natesto®, Striant®, Testim®, Vogelxo™)
Glaucoma	Lumigan®, Xalatan® [generics], Travatan®, Travatan Z®, Zioptan®
Compounded Medications*	Select medications * *A compounded medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available.*
Diabetes	GLP-1 agonists (Byetta®, Bydureon®, Trulicity®, Victoza®)
	Symlin®
Rosacea	Mirvaso®, Rhofade™ cream
Narcolepsy	Provigil®, Nuvigil®, Xyrem®
Nutritional Supplements	Nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids
Pain	Oral-intranasal fentanyl (Abstral®, Actiq®, Fentora®, Lazanda®, Onsolis®, Subsys®)
	Lidoderm®
Testosterone Products	Injectable, oral, topical/buccal/nasal products (AndroGel®, Androderm®, Axiron®, Delatestryl®, Depo®-Testosterone, Fortesta®, methyltestosterone, Natesto®, Striant®, Testim®, testosterone cream, testosterone ointment, testosterone powder, Vogelxo® topical gel)
Weight Management	Adipex® [phentermine], Bontril® [phendimetrazine], Contrave® [bupropion; naltrexone], Didrex® [benzphetamine], Sanorex® [mazindol], Suprenza™ [phentermine], Tenuate® [diethylpropion], Xenical® [orlistat], Belviq®, Qsymia®, Saxenda®
Dry Eyes	Restasis®, Xiidra®

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.

Table 25. Current examples of top drug classes that may require prior authorization for medical necessity[1]

▪ Dermatological Agents	▪ Insulins
▪ Diabetic Supplies	▪ Nasal Steroids
▪ Epinephrine Auto-Injector Systems	▪ Ophthalmic Agents
▪ Erectile Dysfunction Oral Agents	▪ Opioid Analgesics
▪ Erythropoiesis-Stimulating Agents	▪ Opioid Dependence Agents
▪ Glaucoma	▪ Osteoarthritis – Hyaluronic Acid Derivatives
▪ Growth Hormones	▪ Osteoporosis Therapy
▪ Hepatitis C Agents	▪ 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.[1]

Drug Utilization Review Program

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

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

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

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

Exclusions

Benefits exclude:

- 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 health care 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.

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

Deductible – A deductible is the dollar amount you must pay during a plan year before the copayments 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 copayments during the year for prescription drugs that are covered by Express Scripts. Once you reach this maximum, you will have no more copayments for covered drugs. Payments for a brand drug when there is an exact generic equivalent and for drugs not covered by the plan do not count toward the out-of-pocket 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, extension 1.

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

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

Member Appeals

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 6:
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 mass.gov/gic.

Required and permitted uses and disclosures

We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make *without* your authorization:

Payment activities

The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health care operations

The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

To provide you information on health-related programs or products

Such information may include alternative medical treatments or programs or about health-related products and services, subject to limits imposed by law as of September 23, 2013.

Other permitted uses and disclosures

The GIC may use and share PHI as follows:

- ❑ To resolve complaints or inquiries made by you or on your behalf (such as appeals);
- ❑ To enable business associates that perform functions on our behalf or provide services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. Our business associates are also directly subject to federal privacy laws;
- ❑ For data breach notification purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access or disclosure of your health information;
- ❑ To verify agency and plan performance (such as audits);
- ❑ To communicate with you about your GIC-sponsored benefits (such as your annual benefits statement);
- ❑ For judicial and administrative proceedings (such as in response to a court order);
- ❑ For research studies that meet all privacy requirements; and
- ❑ To tell you about new or changed benefits and services or health care choices.

Required disclosures

The GIC **must** use and share your PHI when requested by you or someone who has the legal right to make such a request on your behalf (your Personal representative), when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations that assist us

In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI and also have direct responsibility to protect your PHI imposed by federal law.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your rights

You have the right to:

- ❑ Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.

- ❑ Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this by in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
- ❑ Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research;
- ❑ Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- ❑ Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
- ❑ Receive notification of any breach of your unsecured PHI.
- ❑ Receive a separate paper copy of this notice upon request. (An electronic version of this notice is on our website at mass.gov/gic.)

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call 617-727-2310, extension 1 or TTY for the deaf and hard of hearing at 617-227-8583.

Important notice from the GIC about your prescription drug coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with UniCare State Indemnity Plan/Community Choice 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 www.dol.gov/VETS. An interactive online USERRA Advisor can be viewed at www.dol.gov/elaws/userra.htm. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information about your GIC coverage, please contact the Group Insurance Commission at 617-727-2310, ext. 1.

Appendix B: Community Choice Hospitals

Athol

Athol Memorial Hospital
2033 Main Street
Athol, MA 01331
978-249-3511

Attleboro

Sturdy Memorial Hospital
211 Park Street
Attleboro, MA 02703
508-222-5200

Ayer

Nashoba Valley Medical Center
200 Groton Road
Ayer, MA 01432
978-784-9000

Beverly

Beverly Hospital
85 Herrick Street
Beverly, MA 01915
978-922-3000

Boston

Beth Israel Deaconess Medical Center – Boston
330 Brookline Avenue
Boston, MA 02215
617-667-7000

Carney Hospital
2100 Dorchester Avenue
Dorchester, MA 02124
617-296-4000

Children's Hospital Boston
300 Longwood Avenue
Boston, MA 02115
617-355-6000

Boston *(continued)*

Dana-Farber Cancer Institute
(Boston location only)
450 Brookline Avenue
Boston, MA 02215
866-408-3324

Note: *Dana-Farber often admits patients to Brigham and Women's Hospital for inpatient care. To avoid paying non-Community Choice member costs, please contact UniCare if you are admitted to the Brigham from Dana-Farber.*

Massachusetts Eye and Ear
243 Charles Street
Boston, MA 02114
617-523-7900

New England Baptist Hospital
125 Parker Hill Avenue
Boston, MA 02120
617-754-5000

St. Elizabeth's Medical Center
736 Cambridge Street
Brighton, MA 02135
617-789-3000

Brockton

Brockton Hospital
680 Center Street
Brockton, MA 02302
508-941-7000

Good Samaritan Medical Center
235 North Pearl Street
Brockton, MA 02301
508-427-3000

Burlington

Lahey Hospital & Medical Center – Burlington
41 Burlington Mall Road
Burlington, MA 01805
781-744-5100

Cambridge

Cambridge Hospital
1493 Cambridge Street
Cambridge, MA 02139
617-665-1000

Mount Auburn Hospital
330 Mt. Auburn Street
Cambridge, MA 02138
617-492-3500

Concord

Emerson Hospital
133 Old Road Nine Acre Corner
Concord, MA 01742
978-369-1400

Everett

Everett Hospital
(formerly Whidden Hospital)
103 Garland Street
Everett, MA 02149
617-389-6270

Fall River

Charlton Memorial Hospital
363 Highland Avenue
Fall River, MA 02720
508-679-3131

St. Anne's Hospital
795 Middle Street
Fall River, MA 02721
508-674-5600

Fitchburg

Burbank Hospital (HealthAlliance)
275 Nichols Road
Fitchburg, MA 01420
978-343-5000

Framingham

Framingham Union Hospital
115 Lincoln Street
Framingham, MA 01702
508-383-1000

Gardner

Heywood Hospital
242 Green Street
Gardner, MA 01440
978-632-3420

Gloucester

Addison Gilbert Hospital
298 Washington Street
Gloucester, MA 01930
978-283-4000

Great Barrington

Fairview Hospital
29 Lewis Avenue
Great Barrington, MA 01230
413-528-8600

Greenfield

Baystate Franklin Medical Center
164 High Street
Greenfield, MA 01301
413-773-0211

Haverhill

Merrimack Valley Hospital (Holy Family)
140 Lincoln Avenue
Haverhill, MA 01830
978-374-2000

Holyoke

Holyoke Medical Center
575 Beech Street
Holyoke, MA 01040
413-534-2500

Hyannis

Cape Cod Hospital
27 Park Street
Hyannis, MA 02601
508-771-1800

Lawrence

Lawrence General Hospital
1 General Street
Lawrence, MA 01841
978-683-4000

Leominster

Leominster Hospital (HealthAlliance)
60 Hospital Road
Leominster, MA 01453
978-466-2000

Lowell

Lowell General Hospital
295 Varnum Avenue
Lowell, MA 01854
978-937-6000

Saints Medical Center
One Hospital Drive
Lowell, MA 01852
978-458-1411

Medford

Lawrence Memorial Hospital
170 Governors Avenue
Medford, MA 02155
781-306-6000

Melrose

Melrose-Wakefield Hospital
585 Lebanon Street
Melrose, MA 02176
781-979-3000

Methuen

Holy Family Hospital
70 East Street
Methuen, MA 01844
978-687-0151

Milford

Milford Regional Medical Center
14 Prospect Street
Milford, MA 01757
508-473-1190

Milton

Milton Hospital (Beth Israel Deaconess)
199 Reedsdale Road
Milton, MA 02186
617-696-4600

Natick

Leonard Morse Hospital
67 Union Street
Natick, MA 01760
508-650-7000

Needham

Needham Hospital (Beth Israel Deaconess)
148 Chestnut Street
Needham, MA 02192
781-453-3000

New Bedford

St. Luke's Hospital
101 Page Street
New Bedford, MA 02740
508-997-1515

Newburyport

Anna Jaques Hospital
25 Highland Avenue
Newburyport, MA 01950
978-463-1000

Northampton

Cooley Dickinson Hospital
30 Locust Street
Northampton, MA 01061
413-582-2000

Norwood

Norwood Hospital
800 Washington Street
Norwood, MA 02062
781-769-4000

Palmer

Wing Hospital (Baystate)
40 Wright Street
Palmer, MA 01069
413-283-7651

Peabody

Lahey Medical Center – Peabody
1 Essex Center Drive
Peabody, MA 01960
978-538-4000

Pittsfield

Berkshire Medical Center
725 North Street
Pittsfield, MA 01201
413-447-2000

Plymouth

Plymouth Hospital (Beth Israel Deaconess)
275 Sandwich Street
Plymouth, MA 02360
508-746-2000

South Weymouth

South Shore Hospital
55 Fogg Road at Route 18
South Weymouth, MA 02190
781-624-8000

Southbridge

Harrington Memorial Hospital
100 South Street
Southbridge, MA 01550
508-765-9771

Springfield

Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199
413-794-0000

Mercy Medical Center
271 Carew Street
Springfield, MA 01104
413-748-9000

Taunton

Morton Hospital
88 Washington Street
Taunton, MA 02780
508-828-7000

Ware

Mary Lane Hospital (Baystate)
85 South Street
Ware, MA 01082
413-967-6211

Wareham

Tobey Hospital
43 High Street
Wareham, MA 02571
508-295-0880

Westfield

Noble Hospital (Baystate)
115 West Silver Street
Westfield, MA 01085
413-568-2811

Winchester

Winchester Hospital
41 Highland Avenue
Winchester, MA 01890
781-729-9000

Worcester

Saint Vincent Hospital
123 Summer Street
Worcester, MA 01608
508-363-5000

Appendix C: Forms

This appendix contains the following forms:

- ❑ Bill Checker Program Form
- ❑ Diabetes Prevention Program Reimbursement Form
- ❑ Fitness Club Reimbursement Form

You can download these and other forms, such as claim forms, from unicarestateplan.com.

If you don't have access to a computer, you can request forms by calling UniCare Member Services at 833-663-4176.

Bill Checker Program Form

See “Checking your claims for billing accuracy” on page 117
for details about the Bill Checker program.

What is the Bill Checker program?

UniCare’s Bill Checker program lets you share in any savings that the Plan realizes if you find errors on your medical bills.

UniCare encourages you to always review your medical bills for accuracy. If you find an error and get a corrected bill from your provider, send copies of both bills to UniCare for review. You will get 25% of any savings that result from a confirmed billing error.

What else do I need to know?

- ❑ Send the completed Bill Checker form, along with copies of the original and corrected bills, to the address shown at the bottom of this page.
- ❑ Write your UniCare member ID number prominently on all the documents that you are sending to UniCare and keep copies for your own records.
- ❑ Note that duplicate claims and services are not covered by UniCare and will not be reviewed.
- ❑ Call UniCare Member Services at 833-663-4176 if you have any other questions.

1. Enrollee ID (from UniCare ID card)	**2. Name of service provider**
3. Enrollee name (Last, First, MI)	**4. Date of service**
5. Patient name (if different from enrollee)	**6. ☐ Inpatient ☐ Outpatient**

Write your member ID on all paperwork.
Send this form and copies of the original and corrected bills to:

UniCare Member Services
PO Box 9016
Andover, MA 01810-0916

Diabetes Prevention Program Reimbursement Form

See "Diabetes prevention program reimbursement" on page 48 for details about what is covered under the diabetes prevention program reimbursement benefit.

What information do I need to provide?

1. A completed copy of this form.
2. A statement from a program representative showing that you have paid for and completed at least 20 sessions in the program. This statement must be on program letterhead and have an authorized signature.
3. Proof of payment (at least one of the following):
   - ❑ An itemized receipt from the program that details what you paid
   - ❑ A credit card statement or receipt
   - ❑ Your canceled check

PART A: About the UniCare member				
Last name		First name		MI
Date of birth (MM/DD/YYYY)	Sex ❑ Male ❑ Female	Relationship to enrollee ❑ Self ❑ Spouse ❑ Child ❑ Other (specify)		
Street address		City	State	ZIP code

PART B: About the UniCare plan enrollee (shown on your UniCare ID card)		
ID number	Group number	
Last name	First name	MI

PART C: About the diabetes prevention program			
Program name and/or location	Program start and end dates		
Street address	City	State	ZIP code
Amount of reimbursement requested **$**	Total cost of program **$**		

Write your member ID on all paperwork.
Send this form with your proof of payment and program statement to:

UniCare State Indemnity Plan
Diabetes Prevention Program Reimbursement
PO Box 9016
Andover, MA 01810-0916

Fitness Club Reimbursement Form

See "Fitness club reimbursement" on page 57 for details about what is covered under the fitness club reimbursement benefit.

What information do I need to provide?

1. A completed copy of this form
2. Proof of payment (at least one of the following):
   - ❑ Itemized receipts from the fitness club that shows how much you paid and for what period of time
   - ❑ Copies of receipts for fitness club membership dues
   - ❑ Credit card statement or receipts
   - ❑ Statement from fitness club showing that payment was made (statement must be on the club's letterhead and have an authorized signature)

What else do I need to know?

- ❑ Write your UniCare member ID number prominently on all the receipts and documents that you are sending to UniCare and keep copies of all your paperwork for your records.
- ❑ We recommend that you send proof of payment for the entire amount instead of making several requests for lesser amounts.
- ❑ Call UniCare Member Services at 833-663-4176 if you have any other questions.

1. Enrollee name (Last, First, MI)	**2. Enrollee address**
3. Member ID (from UniCare ID card)	
4. Enrollee birth date	**5. Member name (if different from enrollee)**
6. Name of fitness club	**7. Member's relationship to enrollee**
8. Requested reimbursement amount **$**	**9. What months are you requesting reimbursement for? (Example: 7/2018 through 12/2018)**

Write your member ID on all paperwork.
Send this form and your proof of payment to:

UniCare State Indemnity Plan
Fitness Club Reimbursement
PO Box 9016
Andover, MA 01810-0916

Appendix D: Federal and State Mandates

Premium assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage using funds from their Medicaid or CHIP program. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office, or dial **877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor electronically at www.askebsa.dol.gov or call 866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums.
The following list of states is current as of January 31, 2017.
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)

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+: Colorado.gov/HCPF/Child-Health-Plan-Plus

CHP+ Customer Service: 800-359-1991/ State Relay 711

FLORIDA – Medicaid

Website: http://flmedicaidtplrecovery.com/hipp/

Phone: 877-357-3268

GEORGIA – Medicaid

Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment

Phone: 404-656-4507

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: http://www.indianamedicaid.com
Phone 800-403-0864

IOWA – Medicaid

Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp

Phone: 888-346-9562

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/

Phone: 785-296-3512

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/default.htm

Phone: 800-635-2570

LOUISIANA – Medicaid

Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331

Phone: 888-695-2447

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html

Phone: 800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/

Phone: 800-462-1120

MINNESOTA – Medicaid

Website: http://mn.gov/dhs/people-we-serve/seniors/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://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx

Phone: 855-632-7633

NEVADA – Medicaid

Medicaid Website: https://dwss.nv.gov/

Medicaid Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid

Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf

Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/

Medicaid Phone: 609-631-2392

CHIP Website: http://www.njfamilycare.org/index.html

CHIP Phone: 800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/

Phone: 800-541-2831

NORTH CAROLINA – Medicaid

Website: https://dma.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: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm

Phone: 800-692-7462

RHODE ISLAND – Medicaid

Website: http://www.eohhs.ri.gov/

Phone: 401-462-5300

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

Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm

Medicaid Phone: 800-432-5924

CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm

CHIP Phone: 855-242-8282

WASHINGTON – Medicaid

Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program

Phone: 800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx

Phone: 877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf

Phone:-800-362-3002

WYOMING – Medicaid

Website: https://wyequalitycare.acs-inc.com/

Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877-267-2323, Menu Option 4, Ext. 61565[1]

1 OMB Control Number 1210-0137 (expires 12/31/2019)

Coverage for reconstructive breast surgery

Coverage is provided for reconstructive breast surgery as follows:

1. All stages of breast reconstruction following a mastectomy
2. Reconstruction of the other breast to produce a symmetrical appearance after mastectomy
3. Prosthetics and treatment of physical complications of all stages of mastectomy, including lymphedemas

Benefits for reconstructive breast surgery will be payable on the same basis as any other illness or injury under the Plan, including the application of appropriate deductibles and coinsurance amounts.

Several states have enacted similar laws requiring coverage for treatment related to mastectomy. If the law of your state is applicable and is more generous than the federal law, your benefits will be paid in accordance with your state's law.

Minimum maternity confinement benefits

Coverage is provided for inpatient hospital services for a mother and newborn child for a minimum of:

1. 48 hours following an uncomplicated vaginal delivery, and
2. 96 hours following an uncomplicated caesarean section

Any decision to shorten the minimum confinement period will be made by the attending physician in consultation with the mother. If a shortened confinement is elected, coverage will include one home visit for post-delivery care.

Home post-delivery care is defined as health care provided to a woman at her residence by a physician, registered nurse or certified nurse midwife. The health care services provided must include, at a minimum:

1. Parent education
2. Assistance and training in breast or bottle feeding, and
3. Performance of necessary and appropriate clinical tests

Any subsequent home visits must be clinically necessary and provided by a licensed health care provider.

You must notify the Plan within 24 hours – one business day – of being admitted to the hospital. Please call UniCare Member Services at 833-663-4176 if you have questions about these benefits.

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 health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the outcome of the appeal

If you appeal a claim involving urgent/concurrent care

UniCare will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim

UniCare will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim

UniCare will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

Appeal denial

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from UniCare will include all pertinent information set forth in "Notice of adverse benefit determination" on page 184.

External review

If the outcome of the appeal is adverse to you, you may be eligible for an independent external review pursuant to federal law.

Unless you are filing an expedited external review, you must first file an appeal with UniCare before you can pursue an external review. You must submit your request for external review to UniCare within four months of the notice of UniCare's adverse determination of your appeal.

A request for an external review must be in writing unless UniCare determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for your appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an expedited external review without filing an appeal or while simultaneously pursuing an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including UniCare's decision, can be exchanged by telephone, fax, or other similar method.

To proceed with an expedited external review, you or your authorized representative must contact UniCare at the number shown on your blue UniCare ID card and provide at least the following information:

- ❑ The identity of the claimant;
- ❑ The dates of the medical service;
- ❑ The specific medical condition or symptom;
- ❑ The provider's name;
- ❑ The service or supply for which approval of benefits was sought; and
- ❑ Any reasons why the appeal should be processed on a more expedited basis.

All other requests for external review should be submitted in writing unless UniCare determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

UniCare State Indemnity Plan
P.O. Box 2011
Andover, MA 01810

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek external review will not affect your rights to any other benefits under this health care plan. The external review decision is final and binding on all parties except for any relief available through applicable state laws.

Requirement to file an appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's appeals process before filing a lawsuit or taking other legal action of any kind against the Plan.

We reserve the right to modify the policies, procedures and time frames in this section upon further clarification from the Department of Health and Human Services and the Department of Labor.

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Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

You have the right to get this information and help in your language for free. Call the member services number on your ID card for help. (TTY/TDD: 711)

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة.
(TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。
(TTY/TDD: 711)

French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Greek

Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Gujarati

તમે તમારી ભાષામાં મફતમાં આ માહિતી અને મદદ મેળવવાનો અધિકાર ધરાવો છો. મદદ માટે તમારા આઈડી કાર્ડ પરના મેમ્બર સર્વિસ નંબર પર કોલ કરો. (TTY/TDD: 711)

Haitian

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi

आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Khmer

អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមាននៅលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។ (TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Lao

ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກທີ່ໃຫ້ໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. (TTY/TDD: 711)

Polish

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe

Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Notice of nondiscrimination

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. 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 to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with 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 or by calling 800-368-1019 (TDD: 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

To find out about ...

UNICARE®

An Anthem Company

UniCare State Indemnity Plan
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Andover, MA 01810-0916
833-663-4176
unicarestateplan.com

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