The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.unicarestateplan.com/pdf/Series4HBFY20.pdf or call 833-663-4176. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 833-663-4176 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network (PLUS) providers: **$500**/person or **$1,000**/family For out-of-network (non-PLUS) providers: **$500**/person or **$1,000**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and in-network behavioral health services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, for prescription drug coverage: **$100**/person or **$200**/family	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network medical, emergency, prescription drug and behavioral health (shared): **$5,000**/person or **$10,000**/family Out-of-network medical and behavioral health (shared): **$5,000**/person or **$10,000**/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other familiy members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. Go to unicarestateplan.com or call 833-663-4176 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart apply both before and after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	With a Patient-Centered Primary Care PCP: $15 copay/visit All other PCPs: $20 copay/visit Deductible does not apply	$20 copay/visit and 20% coinsurance	None
	Specialist visit	In MA: Tier 1: $30 copay/visit Tier 2: $60 copay/visit Tier 3: $75 copay/visit Outside MA and other specialists: $60 copay/visit Deductible does not apply	$60 copay/visit and 20% coinsurance	None
	Preventive care/screening/ immunization	No charge Deductible does not apply	No charge Deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (X-ray, blood work)	No charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$100 copay/day	$100 copay/day and 20% coinsurance	Preauthorization is required for some procedures. If you don't get preauthorization, benefits could be reduced by up to $500.
If you need drugs to treat your illness or condition ***Benefits provided by Express Scripts*** More information about prescription drug coverage is available at	Tier 1 – Generic drugs	$10 copay/prescription (retail) $25 copay/prescription (mail order)		Retail cost share is for up to a 30-day supply; mail order cost share is for up to a 90-day supply. Some drugs require prior authorization to be covered. Some drugs have quantity limitations. A 90-day supply of maintenance medications may be obtained at a CVS Pharmacy for the applicable mail order copay. If a drug
	Tier 2 – Preferred brand and some generic drugs	$30 copay/prescription (retail) $75 copay/prescription (mail order)		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
express-scripts.com Phone: 855-283-7679	Tier 3 – Non-preferred brand drugs	$65 copay/prescription (retail) $165 copay/prescription (mail order)		has a generic equivalent, and you buy the brand name (even if your physician indicates no substitutions), you will pay the generic-level copay plus the cost difference between the generic and the brand name drug.
	Specialty drugs	Limited to a 30-day supply with appropriate tier copay (see above) when purchased at a designated specialty pharmacy.		Limited to a 30-day supply. Must be filled through Accredo, an Express Scripts specialty pharmacy. Some drugs require prior authorization to be covered. Some drugs have quantity limitations. Some specialty drugs may also be covered under your medical benefit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	At a hospital facility in MA: Tier 1: $110 copay/calendar quarter Tier 2: $110 copay/calendar quarter Tier 3: $250 copay/calendar quarter At a hospital facility outside MA: $110 copay/calendar quarter	$110 copay/calendar quarter and 20% coinsurance	Preauthorization is required for some surgeries. If you don't get preauthorization, benefits could be reduced by up to $500.
		At a non-hospital facility: No charge	20% coinsurance	
	Physician/surgeon fees	No charge	20% coinsurance	
If you need immediate medical attention	Emergency room care	$100 copay/visit (waived if admitted)	$100 copay/visit (waived if admitted)	None
	Emergency medical transportation	No charge	No charge	Covered only for transportation to the nearest facility equipped to treat the condition.
	Urgent care	$20 copay/visit Deductible does not apply	$20 copay/visit Deductible does not apply	Applies to stand-alone, non-hospital-owned facilities only.
If you have a hospital stay	Facility fee (e.g., hospital room)	Tier 1: $275 copay/calendar quarter Tier 2: $500 copay/calendar quarter Tier 3: $1,500 copay/calendar quarter	$500 copay/calendar quarter and 20% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by up to $500.
	Physician/surgeon fees	No charge	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	Individual and family therapy: $20 copay/visit Group therapy, medication management, and telehealth services: $15 copay/visit Deductible does not apply	$30 copay/visit, plus any charges over the allowed amount	**Mental Health Services:** Preauthorization required for outpatient therapy (individual/family) beyond 26. **Substance Use Disorder Services:** Preauthorization is not required for treatment from Massachusetts Department of Public Health (DPH) licensed providers. For treatment from non-DPH licensed providers, preauthorization is required for outpatient therapy (individual/family) beyond 26.
	Inpatient services	$200 copay/calendar quarter Deductible does not apply	$200 copay/calendar quarter and 20% coinsurance	**Mental Health Services**: Services in a general hospital or psychiatric hospital. May require preauthorization. **Substance Use Disorder Services**: Services in a general hospital or substance use disorder facility. Preauthorization is not required for in-network facilities, or for out-of-network facilities licensed by the Massachusetts DPH. Preauthorization is required for out-of-network facilities that are outside of Massachusetts only.
If you are pregnant	Office visits	$30/60/75 copay for first visit Deductible does not apply	$60 copay for first visit and 20% coinsurance	Most maternity care is billed as a global (all-inclusive) service so you owe an office visit copay for the first visit only. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound). Preauthorization is required for delivery. If you don't get preauthorization, benefits could be reduced by up to $500.
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	Tier 1: $275 copay/calendar quarter Tier 2: $500 copay/calendar quarter Tier 3: $1,500 copay/calendar quarter	$500 copay/calendar quarter and 20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by up to $500.
	Rehabilitation services	Physical and occupational therapy: $20 copay/visit Deductible does not apply	Physical and occupational therapy: $20 copay/visit	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by up to $500.
		Speech therapy: No charge Deductible does not apply	Speech therapy: 20% coinsurance	Limit of 20 visits/plan year
	Habilitation services	Early intervention services for children under age 3: No charge Deductible does not apply	Early intervention services for children under age 3: No charge Deductible does not apply	None
	Skilled nursing care	20% coinsurance	20% coinsurance	Limit of 45 days/plan year in an inpatient facility
	Durable medical equipment	No charge Deductible does not apply to breast pumps	20% coinsurance Deductible does not apply to breast pumps	Preauthorization is required if costs will be more than $1,000. If you don't get preauthorization, benefits could be reduced by up to $500.
	Hospice services	No charge	20% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Optometrist: $60 copay/visit Ophthalmologist In MA: Tier 1: $30 copay/visit Tier 2: $60 copay/visit; Tier 3: $75 copay/visit Ophthalmologist outside MA: $60 copay/visit Deductible does not apply	$60 copay/visit and 20% coinsurance Deductible does not apply	Routine eye exams including refraction and glaucoma testing Limit of one exam every 24 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Long-term care

* For more information about limitations and exceptions, see the plan or policy document at www.unicarestateplan.com/pdf/Series4HBFY20.pdf.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery • Chiropractic care (limit of 20 visits/plan year) • Hearing aids • Infertility treatment	• Non-emergency care when traveling outside the U.S. • Private duty nursing (at home only) • Routine eye care (adult)	• Routine foot care (when diagnosis is diabetes or peripheral vascular disease) • Weight loss programs (when BMI is 40 or higher)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. Contact the Group Insurance Commission's Public Information Unit at 617-727-2300; the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa; or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

UniCare Life and Health Insurance Company
Grievances and Appeals
P.O. Box 2011
Andover, MA 01810-0035
833-663-4176

Additionally, a consumer assistance program can help you file your appeal. Contact:

Massachusetts Office of Health Care for All
30 Winter Street, Suite 1004
Boston, MA 02108
800-272-4232
www.hcfama.org/helpline

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.unicarestateplan.com/pdf/Series4HBFY20.pdf.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$600**
Specialist copayment	**$30/60/75**
Hospital (facility) copayment	**$275/500/1,500**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$540
Copayments	$280
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$880**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$600**
Specialist copayment	**$30/60/75**
Hospital (facility) copayment	**$275/500/1,500**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copayments	$840
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,460**

Mia's Simple Fracture
(in-network emergency room visit and follow-up care)

The plan's overall deductible	**$600**
Specialist copayment	**$30/60/75**
Hospital (facility) copayment	**$275/500/1,500**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(X-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$240
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$740**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

(TTY/TDD: 711)

(Arabic) *(العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 833-663-4176*

Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 833-663-4176。

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le 833-663-4176.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο 833-663-4176.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો 833-663-4176.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele 833-663-4176.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें 833-663-4176.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero 833-663-4176.

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ 833-663-4176 ។

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 833-663-4176 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ 833-663-4176.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: 833-663-4176.

Language Access Services:

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para 833-663-4176.

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. 833-663-4176.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al 833-663-4176.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi 833-663-4176.

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: 1- 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.