SERIES 4

UNICARE STATE INDEMNITY PLAN PLUS

Member Handbook for Active Employees and Non-Medicare Retirees

Effective July 1, 2017

UniCare®

An Anthem Company

Commonwealth of Massachusetts
Group Insurance Commission

UNICARE STATE INDEMNITY PLAN/PLUS MEMBER HANDBOOK

For active employees and non-Medicare retirees

Effective July 1, 2017

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, 2017. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIALS EACH YEAR TO DETERMINE WHETHER YOUR HEALTH PLAN MEETS THE LATEST STANDARDS.

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

Interpreting and Translating Services

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

If you 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.

Who to Contact

For questions about your medical plan	
UniCare State Indemnity Plan Customer Service Center P.O. Box 9016 Andover, MA 01810-0916 800-442-9300 (toll free) TTY: 711 contact.us@anthem.com unicarestateplan.com	▪ What your benefits are for a particular medical service or procedure ▪ The status of (or a question about) a medical claim ▪ How to find a doctor, hospital or other medical provider ▪ Information in "Your Medical Plan" (Part 1 of this handbook)
For questions about your prescription drug plan	
CVS Caremark 877-876-7214 (toll free) TTY: 800-238-0756 caremark.com	▪ What your benefit is for a prescription drug ▪ The status of (or a question about) a prescription drug claim ▪ Where to get prescriptions filled ▪ Which drugs are covered ▪ Information in "Your Prescription Drug Plan" (Part 2 of this handbook)
For questions about your behavioral health plan	
Beacon Health Options 855-750-8980 (toll free) TTY: 711 beaconhealthoptions.com/gic	▪ What your benefits are for mental health services ▪ What your benefits are for substance use disorder services ▪ What your benefits are for the Enrollee Assistance Program (EAP) ▪ The status of (or a question about) a mental health, substance use disorder, or EAP claim ▪ Information in "Your Behavioral Health Plan" (Part 3 of this handbook)
For general health questions after hours (not about plan benefits or coverage)	
24/7 NurseLine 800-424-8814 (toll free) Select the NurseLine option	▪ How to prepare for an upcoming medical procedure ▪ What side effects are possible from your medication ▪ Whether to go to an urgent care center or call your doctor ▪ See page 115 for more information

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

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YOUR MEDICAL PLAN

Description of Benefits

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

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1: Getting started with PLUS

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

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

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

Introducing your medical plan

UniCare State Indemnity Plan/PLUS 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.

About PLUS providers

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

- ❑ All physicians and hospitals in Massachusetts
- ❑ Physicians and hospitals in other states who are in the UniCare provider network
- ❑ Preferred vendors
- ❑ Specialized health facilities, such as dialysis centers, that have contracted to accept UniCare's payment as payment in full

See "Types of health care providers" on pages 89-92 to find out more about these providers.

Prescription drugs and behavioral health

- ❑ Your **prescription drug benefits** are administered by **CVS Caremark**. These benefits are described in Part 2 of this handbook (pages 123-139).
- ❑ Your **behavioral health benefits** are administered by **Beacon Health Options**. These benefits include coverage for mental health, substance use disorder and the Enrollee Assistance Program (EAP). They are described in Part 3 of this handbook (pages 141-168).

Using this handbook

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

What the handbook symbols mean

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

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

☎ **Needs preapproval** – You (or someone acting for you) must tell UniCare if you are having this service or procedure. If you don't do so, your benefits may be reduced by up to $500. See "Medical services that need to be preapproved" on page 15 for details about this requirement.

✓ **Use UniCare preferred vendors** – To get the best benefit, use a UniCare preferred vendor for this service or product. See page 29 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, please call UniCare Customer Service at 800-442-9300 and ask that the form be sent to you. Or, you can download it from unicarestateplan.com.

To learn more about how UniCare coordinates benefits with other health plans, turn to "Coordinating benefits with other health plans (COB)" on page 108.

About your ID cards

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

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

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

If you live in Massachusetts

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

If you live outside of Massachusetts

To get the best coverage, members who live outside of Massachusetts should always use PLUS providers in the states where they live (their home states). Although your care is covered at other providers, non-PLUS providers may balance bill you for charges above what the Plan pays. See page 28 to find out more about balance billing.

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

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

Medical services that need to be preapproved

Preapproval confirms that a 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.

If you are scheduled to have one of the services listed in Table 1, you (or someone acting for you) must contact UniCare ahead of time. This notification is required to ensure that there's enough time for the preapproval review to take place. Table 1 shows how much advance notice is required for each service.

If you don't contact UniCare within the amount of time shown in the table, your benefits may be reduced by up to $500, even if the service is covered. If the review finds that the service is not eligible for benefits, you may have to pay the entire cost yourself.

About the notification requirements

Table 1 lists the notification requirements for all the services that need preapproval. For each service in the list, the table also shows:

- **Minimum notice required** – 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℠. AIM is a UniCare-affiliated company that provides support for the preapproval process.

Notifying UniCare

For services that UniCare reviews, contact UniCare Customer Service at:

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

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 of the service.
- **Where the service will take place** – The name and contact information of the facility where the service will occur.
- **Who the ordering doctor is** – The name and contact information of the doctor who ordered the service.

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)
aimspecialtyhealth.com/goweb
aimspecialtyhealth.com/gowebsleep

If you're not sure if you need preapproval

If you're not sure if the service you're having is on the list, or if you don't know the medical term for the service, ask your doctor to review Table 1. Or, you or your doctor can call UniCare at 800-442-9300 to find out.

Important points to remember

- **If you don't provide notice within the time shown in Table 1, 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.**

Notification requirements for preapprovals

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

Table 1. ☎ Notification Requirements for Preapprovals

	Minimum notice required	Notify
✓ **BPAP and CPAP equipment**	1 business day before ordering	AIM
Breast cancer genetic testing (BRCA)	7 days before testing	UniCare
Chiropractic care and osteopathic manipulative therapy for children under 13	1 business day before services start	UniCare
Cleft palate and cleft lip services	7 days before services start	UniCare
Colonography (virtual colonoscopy)	7 days before services start	UniCare
✓ **Durable medical equipment (DME), except oxygen and oxygen equipment**	1 business day before ordering	UniCare
Notify UniCare if the total rental or purchase cost will be more than $1,000		
Echocardiography/echocardiology	7 days before the procedure	AIM
Resting transthoracic echocardiography	Standard echocardiogram (also known as a transthoracic echocardiogram or TTE) or cardiac ultrasound	
Stress echocardiography	Cardiac stress test done with heart stimulation, either by exercise or with intravenous pharmacological (drug) stimulation	
Transesophageal echocardiography	Specialized test that passes a probe with an ultrasound transducer into the esophagus	
✓ **Enteral therapy**	1 business day before services start	UniCare
Prescribed nutrition administered through a tube inserted into the stomach or intestines		
Gender reassignment surgery	21 days before services start	UniCare
High-tech imaging	7 days before the procedure	AIM
CT/CTA scan	Computerized X-ray of part of the body	
MRI/MRA scan	Imaging study of part of the body	
Nuclear cardiology	Studies using radioactive substances and non-invasive techniques to assess heart blood flow and heart muscle function	
PET scan	Specialized three-dimensional imaging of part of the body	
SPECT scan	Specialized three-dimensional imaging of various tissues and organs	
✓ **Home health care**	1 business day before services start	UniCare
Services must be provided by either a home health agency or a visiting nurse association		

Table 1. ☎ Notification Requirements for Preapprovals *(continued)*

	Minimum notice required	Notify
Hospital – Elective admission (non-emergency)	7 calendar days before admission	UniCare
Hospital – Emergency admission, maternity admission, or overnight stay (observation)	Within 24 hours (or next business day)	UniCare
Hyperbaric oxygen therapy	7 days before services start	UniCare
Occupational therapy	1 business day before services start	UniCare
Physical therapy	1 business day before services start	UniCare
Private duty nursing	1 business day before services start	UniCare
Radiation therapy	7 days before the procedure	AIM
Brachytherapy	A form of radiation therapy where a radiation source is placed inside or next to the area requiring treatment	
CyberKnife	Robotic radiosurgery system used for treating tumors and other medical conditions	
IMRT (intensity-modulated radiation therapy)	A type of radiation that shapes the radiation beams to closely approximate the shape of the tumor	
Proton beam	A type of particle therapy using a beam of protons to irradiate diseased tissue	
Traditional radiation	The use of ionizing radiation to control or kill malignant cells	
Skilled nursing facility admission	Within 24 hours (or next business day)	UniCare
Sleep studies (including polysomnography)	7 days before the study	AIM
Sleep studies in either a facility or a home setting		
Specialty drugs	7 days before administration	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** or call UniCare at 800-442-9300. This list may change during the year. For a list of (non-oncology) specialty drugs that require review through the prescription drug plan, see Part 2 of this handbook. Also see restriction #24 on page 79.		

Table 1. ☎ Notification Requirements for Preapprovals *(continued)*

		Minimum notice required	Notify
Surgery		7 days before surgery	UniCare
Back surgery	Including, but not limited to, procedures listed here, as well as any other spinal instrumentation not otherwise listed		
Cardioverter-defibrillator implantation	Surgical implantation of a device to continuously monitor the heart rhythm to detect and correct abnormal heart rhythms		
Cervical fusion	Surgical joining of two or more vertebrae at the cervical levels of the spine; may also be referred to as cervical spine fusion or spinal arthrodesis		
Discectomy – lumbosacral spine (open, percutaneous and endoscopic, and other minimally invasive procedures to treat back pain)	Procedures on the spine using small incisions through the skin and probes, endoscopes or catheters to perform procedures		
Knee arthroscopy	Surgical procedure in which the knee joint is viewed using a small camera in order to get a clear view of the inside of the knee		
Knee meniscal transplant	Transplant of special cartilage into the knee to treat certain types of knee pain and problems		
Laminectomy/laminotomy of the lumbosacral spine	Any surgical procedure removing portions of the vertebra to relieve pressure on the spinal cord or nerve roots in the lower back		
Sinus surgery (including endoscopy)	Any procedure by any method that opens, removes or treats the nasal sinuses, including the use of an endoscope		
Spinal cord stimulator and neuromodulator implantation	Implantation of a device that delivers electrical current directly to specific areas of the spinal cord with implanted electrodes, to treat pain or urinary incontinence		
Spinal fusion of the lumbosacral spine	Surgical procedures in which two or more of the vertebrae in the lower back are fused together		
Spinal instrumentation of the lumbosacral spine	Any surgical procedure by any method to relieve pressure on the spinal cord or nerve roots in the lumbosacral spine (lower back)		
Upper gastrointestinal endoscopy	Examination of the upper gastrointestinal (UGI) area (that is, the esophagus, stomach and duodenum) through a flexible telescopic tube (endoscope) for diagnosis and/or treatment		
Vertebroplasty	Injection of material into the center of a collapsed spinal vertebra to repair fractures		
Transplants (except cornea transplants)		21 days before services start	UniCare
Varicose vein treatment (including sclerotherapy)		7 days before treatment	UniCare

2: What to know about costs

What member costs are (cost sharing)

Member costs are the costs for medical care that are your responsibility to pay (member costs are also known as **cost sharing** or **out-of-pocket costs**). There are three different types of member costs. These costs are separate and unrelated; they apply in different situations and are for different services. The three types of member costs are:

- **Deductible** – This is a fixed amount you pay toward services each year before the Plan starts paying benefits for those services. Once you have paid the full amount, you won't owe any more of that deductible until the start of the following plan year.

  Under PLUS, you have two medical deductibles: one for services you get from PLUS providers and one for services from non-PLUS providers. See pages 21-22 for details about these medical deductibles. (For details about the separate prescription drug deductible, see Part 2 of this handbook.)

- **Copays (copayments)** – A copay is a set amount you pay when you get certain medical services. For example, you pay a copay when you see your doctor for a sore throat, or when you get outpatient surgery at a hospital. The dollar amount of your copay depends on the service you're getting and the provider you're using. See pages 23-26 for details about copays.
- **Coinsurance** – This is your share of the cost of a covered service when the service isn't covered at 100%. For example, if the Plan pays 80% of the allowed amount for a service, you are responsible for paying the other 20%. See page 26 for details about coinsurance.

There are caps that limit how much you could pay each plan year for these member costs. These caps, called **out-of-pocket limits**, limit how much you'll spend each plan year on the combination of deductible, copays and coinsurance. See page 26 for details about the out-of-pocket limits.

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

How member costs work

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

After receiving payment from UniCare, your provider will bill you for your member costs; that is, any copay, deductible and coinsurance that UniCare subtracted before paying the provider.

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

About your medical deductible

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

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

Under the PLUS plan, you have two medical deductibles:

- The **PLUS deductible** applies to services you get from PLUS providers
- The **non-PLUS deductible** applies to services from non-PLUS providers and out-of-network behavioral health (mental health/substance use disorder) providers

A separate deductible applies to prescription drugs and is described in Part 2 of this handbook.

Table 2. Medical Deductible Amounts

	PLUS medical deductible When you use PLUS providers	Non-PLUS medical deductible When you use non-PLUS providers and out-of-network behavioral health providers
For an individual	**$500 for one person**	**$500 for one person**
For a family	**$1,000 for the entire family** For any one person in the family, the deductible is capped at $500	**$1,000 for the entire family** For any one person in the family, the deductible is capped at $500

Your PLUS medical deductible

Your PLUS deductible applies when you get services from PLUS providers. PLUS providers are:

- All physicians and hospitals in Massachusetts
- Non-Massachusetts physicians and hospitals who ***are*** in the UniCare provider network
- Preferred vendors
- Specialized health facilities that ***have a contract*** with UniCare

PLUS deductible for an individual

The $500 PLUS individual deductible is the amount you must pay each plan year before UniCare starts to pay for many medical services you get from PLUS providers.

> **Example** – In July, you go to a PLUS provider for a medical problem. You must pay the copay, if there is one, and then up to $500 of your deductible. If the bill is more than that, the Plan pays the covered amount of the remaining charges. However, if the total bill is *less* than $500, you will owe the rest of your deductible the next time you go to a PLUS provider.

PLUS deductible for a family

The $1,000 PLUS family deductible is the most your family could pay each plan year before UniCare starts to pay for many medical services you get from PLUS providers. The most you'll owe for any one family member is $500, until the family as a whole reaches the $1,000 limit.

> **Example** – In July, you and your two children go to a PLUS provider for medical care. All three of you pay $300 deductibles, for a total of $900 toward the family deductible. In August, your spouse goes to a PLUS provider and pays $100 toward the deductible – the rest of your family deductible. Even though no single family member has reached the $500 cap, the family deductible of $1,000 has been met. Therefore, no additional PLUS deductible will apply to your family for the rest of the plan year.

Your non-PLUS medical deductible

Your non-PLUS deductible applies to both non-PLUS medical claims and any claims for out-of-network behavioral health services. This deductible applies when you get services from:

- ❑ Non-Massachusetts physicians and hospitals who ***are not*** in the UniCare provider network
- ❑ Specialized health facilities that ***do not have a contract*** with UniCare
- ❑ Behavioral health providers that ***are not*** in the Beacon Health Options network

Non-PLUS deductible for an individual

The $500 non-PLUS individual deductible is the amount you must pay each plan year before UniCare starts to pay for many medical services you get from non-PLUS providers and out-of-network behavioral health providers.

> **Example** – In July, you get behavioral health services from an out-of-network provider and pay $200 toward your non-PLUS deductible. You now have $300 of this deductible left. In August, you go to a non-PLUS provider for medical care. If this second bill is *more* than $300, you pay $300 – the rest of your non-PLUS deductible – and the Plan pays the covered amount of the remaining charges. However, if this second bill is *less* than $300, then the rest of this deductible will be taken the next time you go to either a non-PLUS provider or an out-of-network behavioral health provider.

Non-PLUS deductible for a family

The $1,000 non-PLUS family deductible is the most your family could pay each plan year before UniCare starts to pay for many medical services you get from non-PLUS providers and out-of-network behavioral health providers. The most you'll owe for any one family member is $500, until the family as a whole reaches the $1,000 limit.

> **Example** – In July, you and your child go to non-PLUS providers for medical care. Both of you pay $400 toward this deductible, for a total of $800 toward the family deductible. In August, your spouse goes to an out-of-network behavioral health provider and pays $200 toward this deductible – the rest of your family deductible. Even though no single family member has reached the $500 cap, the family non-PLUS deductible of $1,000 has been met. Therefore, no additional non-PLUS deductible will apply to your family for the rest of the plan year.

About copays

A **copay** (**copayment**) is a set amount you pay when you get certain medical services. For example, you pay a copay when you see your doctor for a sore throat, or when you get outpatient surgery at a hospital. The dollar amount of your copay depends on the service you're getting and what kind of provider you're seeing. See the tables on pages 25 and 26 for a list of services and copay amounts.

Copays can work in two ways:

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

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

Your copay for inpatient hospital care

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

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

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

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

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

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

Your copay for outpatient surgery

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

Outpatient surgery at a hospital or hospital-owned location

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

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

Outpatient surgery at a non-hospital-owned location

The outpatient surgery copay applies only when you have your surgery at a hospital or hospital-owned location. There's no copay if you have your surgery at a non-hospital-owned ambulatory surgery center or doctor's office. Keep in mind, however, that you'll owe 20% coinsurance if you have your surgery at a non-PLUS ambulatory surgery center (a center without a contract with UniCare).

Copays for office visits and other services

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

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

Table 3. Copays for Office Visits

Type of visit	PLUS providers	Non-PLUS providers
Primary care With a primary care physician (PCP)[1], nurse practitioner, or physician assistant	$20	$20
Primary care at a Patient-Centered Primary Care practice (page 89) With a primary care physician (PCP)[1], nurse practitioner or physician assistant	$15	$15
Specialist – With a physician in Massachusetts ***Tier 1 (excellent)	$30	$30
**Tier 2 (good)	$60	$60
*Tier 3 (standard)	$90	$90
Not tiered[2]	$60	$60
Specialist – With a physician outside Massachusetts	$60	$60
Specialist – With a nurse practitioner or physician assistant	$60	$60
Routine eye exam ▪ With an optometrist	$60	$60
▪ With an ophthalmologist	See specialists (above)	See specialists (above)
Visit to an urgent care center or retail health clinic	$20	$20
LiveHealth Online (page 91)	$15	

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

2 These are physicians who don't have enough data to allow us to score them, such as doctors who are new to practice or specialists who are not tiered through the CPI Initiative (page 93).

Table 4. Copays for Other Medical Services

Type of service	PLUS providers	Non-PLUS providers
Emergency room	$100 (waived if admitted)	$100 (waived if admitted)
☎ **Inpatient hospital care** This copay is waived for readmissions within 30 days of discharge, within the same plan year.	Tier 1[1]: $275 per quarter Tier 2[1]: $500 per quarter Tier 3[1]: $1,500 per quarter Rehab hospitals: $500 per quarter	$500 per quarter
☎ **Complex procedure at a designated hospital (page 57)**	$275 per quarter	$500 per quarter
☎ **Transplant at a Quality Center or Designated Hospital for transplants (page 71)**	$275 per quarter	$275 per quarter
☎ **Outpatient surgery** ▪ At a hospital or hospital-owned location	Tier 1[1]: $110 per quarter Tier 2[1]: $110 per quarter Tier 3[1]: $250 per quarter	$110 per quarter
▪ At a non-hospital-owned location	No copay	No copay
☎ **Outpatient high-tech imaging, such as MRIs, CT scans, PET scans** At a hospital or non-hospital-owned location	$100 per scan (limit of one copay a day)	$100 per scan (limit of one copay a day)
☎ **Physical therapy**	$20	$20
☎ **Occupational therapy**	$20	$20
☎ **Chiropractic care**	$20	$20

About coinsurance

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

Limits to your member costs

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

1 The tier designations of all Massachusetts hospitals are listed in Appendix B.

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

1. The out-of-pocket limit for **medical services from PLUS providers** and **in-network behavioral health services**.
2. The out-of-pocket limit for **medical services from non-PLUS providers** and **out-of-network behavioral health services**.
3. The out-of-pocket limit for **prescription drugs** (see Part 2 of this handbook).

Table 5 lists the dollar limits for both the PLUS and non-PLUS out-of-pocket limits. It also lists which member costs are included (and not included) in both of these limits.

Table 5. Out-of-Pocket Limits

PLUS out-of-pocket limit	Non-PLUS out-of-pocket limit
Dollar limits	
For an individual: $4,000 for one person each plan year	**For an individual:** $5,000 for one person each plan year
For a family: $8,000 for the entire family each plan year; for any one person in the family, the dollar limit is $4,000	**For a family:** $10,000 for the entire family each plan year; for any one person in the family, the dollar limit is $5,000
What is included	
▪ PLUS medical deductible ▪ Copays and coinsurance for services from PLUS providers (including preferred vendors) ▪ Copays and coinsurance for in-network behavioral health services ▪ Copays and coinsurance for emergency services (from any provider)	▪ Non-PLUS medical deductible ▪ Copays and coinsurance for services from non-PLUS providers (including non-preferred vendors) ▪ Copays and coinsurance for out-of-network behavioral health services
What is not included	
▪ Member costs for drugs and services through the prescription drug plan ▪ Premiums ▪ Balance bills (charges above the Plan's allowed amount) ▪ Services not covered by the Plan	

About allowed amounts

UniCare reimburses 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 charges. When a provider asks you to pay for charges above the allowed amount (that is, above the amount paid by insurance), it is called **balance billing**.

The Plan doesn't cover balance bills, and balance bills don't count toward your out-of-pocket limits. Massachusetts providers aren't legally allowed to balance bill you. Outside of Massachusetts, PLUS providers must accept the Plan's allowed amount, so you won't be balance billed as long as you use PLUS providers. However, non-PLUS providers outside of Massachusetts are free to balance bill you.

See "How to use your plan wisely" on page 87 for ways to avoid being balance billed.

When you get care in Massachusetts

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

If you live outside of Massachusetts

If you live outside of Massachusetts, you won't get balance billed as long as you use PLUS providers in the state where you live (your home state). Otherwise, you may be balance billed for the difference between the Plan's allowed amount and the provider's charges. Since the Plan doesn't cover balance bills, payment is your responsibility.

> **Behavioral health services** – You must use a provider in the Beacon Health Options network to avoid getting balance billed for mental health and substance use disorder services, both in and outside of Massachusetts. Behavioral health and EAP benefits are administered by Beacon, not by UniCare. See Part 3 (pages 141-168) for information about these benefits.

When you travel

If you travel outside of either Massachusetts or your home state, you can be balance billed for medical care. Providers in other states may balance bill you for the difference between the Plan's allowed amount and the provider's charges.

If you need urgent care when you travel, you will not be balance billed as long as you go to a Travel Access provider (page 92). Keep in mind, however, that Travel Access providers are for urgent care only. If you get elective care in another state, you may be balance billed by any provider. Since the Plan doesn't cover balance bills, payment is your responsibility.

> **Behavioral health services** – You must use a provider in the Beacon Health Options network to avoid getting balance billed for mental health and substance use disorder services, both in and outside of Massachusetts. Behavioral health and EAP benefits are administered by Beacon, not by UniCare. See Part 3 (pages 141-168) for information about these benefits.

About preferred vendors

Preferred vendors, whether located within or outside of Massachusetts, are PLUS providers. They 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/diabetes 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% and you will owe the 20% coinsurance. (Note that your deductible may also apply, no matter which type of vendor you use.)

✓ In this handbook, the checkmark lets you know when a service has a preferred vendor benefit.

💻 For a list of UniCare preferred vendors, select *Preferred vendors* on the *Members* page of unicarestateplan.com, or call UniCare Customer Service at 800-442-9300 for help.

When you use non-preferred vendors

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

☞ **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.

3: Find out what's covered

Summary of benefits

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

Table 6. Summary of Covered Services

	PLUS providers	Non-PLUS providers	See page
Ambulances	PLUS deductible, then 100%	100% of the first $25, then non-PLUS deductible, then 80%	35
Behavioral health (mental health, substance use disorder and EAP services)	Benefits are administered by Beacon Health Options. See Part 3 of this handbook, or call Beacon at 855-750-8980 (toll free) for more information.		141
Bereavement counseling	PLUS deductible, then 80%, up to a limit of $1,500 per family	Non-PLUS deductible, then 80%, up to a limit of $1,500 per family	53
Cardiac rehab programs	PLUS deductible, then 100%	Non-PLUS deductible, then 80%	36
Chemotherapy	PLUS deductible, then 100%	Non-PLUS deductible, then 80%	37
☎ **Chiropractic care**	$20 copay, then 80%, up to a limit of 20 visits each plan year	$20 copay, then non-PLUS deductible, then 80%, up to a limit of 20 visits each plan year	37
✓ **Diabetes supplies**	PLUS deductible, then 100%	Non-PLUS deductible, then 80%	41
Dialysis	PLUS deductible, then 100%	Non-PLUS deductible, then 80%	42
Doctor and other health care provider services			42
▪ Primary care office visits	$15/20 copay, then 100%	$20 copay, then non-PLUS deductible, then 80%	
▪ Specialist office visits	$30/60/90 copay, then 100%	$30/60/90 copay, then non-PLUS deductible, then 80%	
▪ LiveHealth Online	$15 copay, then 100%	*Not applicable*	
▪ Inpatient hospital	PLUS deductible, then 100%	Non-PLUS deductible, then 80%	
▪ Emergency room treatment	PLUS deductible, then 100%	PLUS deductible, then 100%	

All services must be medically necessary and all charges are subject to the Plan's allowed amount for that service (page 27).

Table 6. Summary of Covered Services *(continued)*

	PLUS providers	Non-PLUS providers	See page
Drug screening	PLUS deductible, then 100%	Non-PLUS deductible, then 80%	43
☎ ✓ **Durable medical equipment (DME)**	PLUS deductible, then 100%	Non-PLUS deductible, then 80%	44
Early intervention programs	100%	100%	45
Emergency room	$100 copay, then PLUS deductible, then 100%	$100 copay, then PLUS deductible, then 100%	46
Eye exams (routine)	$30/60/90 copay, then 100%; covered once every 24 months	$30/60/90 copay, then 80%; covered once every 24 months	48
Eyeglasses and contact lenses	PLUS deductible, then 80%; limited to the initial lenses within six months after an eye injury or cataract surgery	Non-PLUS deductible, then 80%; limited to the initial lenses within six months after an eye injury or cataract surgery	49
Family planning	100%	100%	49
Fitness club reimbursement	$100 per family each plan year	$100 per family each plan year	50
Hearing aids			51
▪ Age 21 and under	100%, up to a limit of $2,000 for each impaired ear every 36 months	100%, up to a limit of $2,000 for each impaired ear every 36 months	
▪ Age 22 and over	100% of the first $500, then 80% of the next $1,500, up to a limit of $1,700 every 24 months	100% of the first $500, then 80% of the next $1,500, up to a limit of $1,700 every 24 months	
Hearing exams	$15/20/30/60/90 copay, then 100%	$20/30/60/90 copay, then non-PLUS deductible, then 80%	52
☎ ✓ **Home health care**	PLUS deductible, then 100%	Non-PLUS deductible, then 80%	52
✓ **Home infusion therapy**	PLUS deductible, then 100%	Non-PLUS deductible, then 80%	53
Hospice care	PLUS deductible, then 100%	Non-PLUS deductible, then 80%	53

All services must be medically necessary and all charges are subject to the Plan's allowed amount for that service (page 27).

Table 6. Summary of Covered Services *(continued)*

	PLUS providers	Non-PLUS providers	See page
☎ **Hospital admissions (inpatient services)**			55
▪ At a hospital or rehab facility (semi-private room)	$275/500/1,500 quarterly copay, then PLUS deductible, then 100%	$500 quarterly copay, then non-PLUS deductible, then 80%	
▪ At a hospital or rehab facility (medically necessary private room)	▪ **First 90 days:** $275/500/1,500 quarterly copay, then PLUS deductible, then 100% ▪ **After 90th day:** 100% of the semi-private room rate	▪ **First 90 days:** $500 quarterly copay, then non-PLUS deductible, then 80% ▪ **After 90th day:** 80% of the semi-private room rate	
▪ Select complex inpatient procedure or neonatal ICU	▪ **At a designated hospital:** $275/500/1,500 quarterly copay, then PLUS deductible, then 100%	▪ **At a non-designated hospital:** $500 quarterly copay, then non-PLUS deductible, then 80%	
▪ At a skilled nursing or long-term care facility	PLUS deductible, then 80%, up to a limit of 45 days each plan year	PLUS deductible, then 80%, up to a limit of 45 days each plan year	
Immunizations (vaccines)	100%	100%	58
Laboratory services			59
▪ Inpatient	PLUS deductible, then 100%	Non-PLUS deductible, then 80%	
▪ Outpatient	PLUS deductible, then 100%	Non-PLUS deductible, then 80%	
▪ Emergency room	PLUS deductible, then 100%	PLUS deductible, then 100%	
Medical services not otherwise specified	PLUS deductible, then 80%	Non-PLUS deductible, then 80%	60
☎ **Occupational therapy**	$20 copay, then 100%	$20 copay, then non-PLUS deductible, then 100%	61
Office visits			42
▪ Patient-centered primary care PCPs	$15 copay, then 100%	*Not applicable*	
▪ All other PCPs	$20 copay, then 100%	$20 copay, then non-PLUS deductible, then 80%	
▪ Specialists	$30/60/90 copay, then 100%	$30/60/90 copay, then non-PLUS deductible, then 80%	
▪ LiveHealth Online	$15 copay, then 100%	*Not applicable*	

All services must be medically necessary and all charges are subject to the Plan's allowed amount for that service (page 27).

Table 6. Summary of Covered Services *(continued)*

	PLUS providers	Non-PLUS providers	See page
Outpatient hospital services not otherwise specified	PLUS deductible, then 100%	Non-PLUS deductible, then 80%	61
✓ **Oxygen**	PLUS deductible, then 100%	Non-PLUS deductible, then 80%	62
Personal Emergency Response Systems (PERS)			62
▪ Installation	PLUS deductible, then 80%, up to a limit of $50	PLUS deductible, then 80%, up to a limit of $50	
▪ Rental fee	PLUS deductible, then 80%, up to $40 each month	PLUS deductible, then 80%, up to $40 each month	
☎ **Physical therapy**	$20 copay, then 100%	$20 copay, then non-PLUS deductible, then 100%	63
Prescription drugs	Benefits are administered by CVS Caremark. See Part 2 of this handbook, or call CVS at 877-876-7214 (toll free) for more information.		123
Preventive care *See Table 10 on page 73.*	100%	100%	73
☎ **Private duty nursing (in a home setting only)**	PLUS deductible, then 80%, up to a limit of $8,000 each plan year	Non-PLUS deductible, then 80%, up to a limit of $8,000 each plan year	64
Prosthetics/orthotics			65
▪ Breast prosthetics	PLUS deductible, then 100%	Non-PLUS deductible, then 100%	
▪ All other prosthetics and orthotics	PLUS deductible, then 80%	Non-PLUS deductible, then 80%	
☎ **Radiation therapy**	PLUS deductible, then 100%	Non-PLUS deductible, then 80%	66
Radiology and imaging			66
▪ Emergency room	PLUS deductible, then 100%	PLUS deductible, then 100%	
▪ Inpatient	PLUS deductible, then 100%	Non-PLUS deductible, then 80%	
▪ ☎ Outpatient high-tech imaging	$100 copay, then PLUS deductible, then 100% (limit of one copay a day)	$100 copay, then non-PLUS deductible, then 80% (limit of one copay a day)	
▪ All other outpatient radiology	PLUS deductible, then 100%	Non-PLUS deductible, then 80%	
Retail health clinics	$20 copay, then 100%	$20 copay, then 100%	46

All services must be medically necessary and all charges are subject to the Plan's allowed amount for that service (page 27).

Table 6. Summary of Covered Services *(continued)*

	PLUS providers	Non-PLUS providers	See page
Speech therapy	100%, up to a limit of 20 visits each plan year	Non-PLUS deductible, then 80%, up to a limit of 20 visits each plan year	67
☎ **Surgery**			68
▪ Inpatient	PLUS deductible, then 100% (you'll also owe the inpatient hospital copay)	Non-PLUS deductible, then 80% (you'll also owe the inpatient hospital copay)	
▪ Outpatient at a hospital location	$110/110/250 quarterly copay, then PLUS deductible, then 100%	$110 quarterly copay, then non-PLUS deductible, then 80%	
▪ Outpatient at a non-hospital-owned location	PLUS deductible, then 100%	Non-PLUS deductible, then 80%	
Tobacco cessation counseling	100%, up to 300 minutes each plan year	100%, up to 300 minutes each plan year	70
☎ **Transplants**			70
▪ At a Quality Center or Designated Hospital for transplants	$275/500/1,500 quarterly copay, then PLUS deductible, then 100%	$500 quarterly copay, then non-PLUS deductible, then 80%	
▪ At another hospital	$275/500/1,500 quarterly copay, then PLUS deductible, then 80%	$500 quarterly copay, then non-PLUS deductible, then 80%	
Urgent care centers	$20 copay, then 100%	$20 copay, then 100%	46

All services must be medically necessary and all charges are subject to the Plan's allowed amount for that service (page 27).

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).

	PLUS providers	Non-PLUS providers
Shot (injection)	PLUS deductible, then 100%	Non-PLUS deductible, then 100%
Allergy serum	PLUS deductible, then 80%	Non-PLUS deductible, then 80%
Office visit	▪ **With a PCP:** $15/20 copay, then 100% ▪ **With a specialist:** $30/60/90 copay, then 100%	▪ **With a PCP:** $20 copay, then non-PLUS deductible, then 80% ▪ **With a specialist:** $30/60/90 copay, then non-PLUS deductible, then 80%

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.

	PLUS providers	Non-PLUS providers
Ambulance transportation	PLUS deductible, then 100%	100% of the first $25, then non-PLUS deductible, then 80%

✕ 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.

Anesthesia

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

	PLUS providers	Non-PLUS providers
Anesthesia and its administration	PLUS deductible, then 100%	Non-PLUS deductible, then 80%

✕ Restrictions:

- Other charges associated with ECT are covered under your behavioral health benefit (see Part 3 of this handbook).
- There is no coverage for anesthesia used for a non-covered procedure.

Autism spectrum disorders

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

Medical services for autism spectrum disorders are covered like any other physical condition. Coverage is subject to all pertinent provisions of the Plan, including use of participating providers, preapproval reviews, and provider payment methods. Medical services needed for diagnosis and treatment (such as occupational therapy) are covered under your medical benefit. Mental health services are covered under your behavioral health benefit. See Part 3 (pages 141-168) for additional information.

Behavioral health services

Benefits for mental health, substance use disorder and the Enrollee Assistance Program (EAP) are administered by Beacon Health Options. These services are called **behavioral health services**. See Part 3 (pages 141-168) for benefits information.

Cardiac rehabilitation (rehab) programs

Cardiac rehab programs are professionally-supervised, multi-disciplinary programs to help people recover from cardiac events such as 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.

	PLUS providers	Non-PLUS providers
Cardiac rehab programs	PLUS deductible, then 100%	Non-PLUS deductible, then 80%

A cardiac rehab program must:

- ❑ 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.
- 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.

	PLUS providers	Non-PLUS providers
Outpatient	PLUS deductible, then 100%	Non-PLUS deductible, then 80%
Inpatient	Covered under the benefit for hospital admissions (page 55)	

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.

	PLUS providers	Non-PLUS providers
☎ **Chiropractic care**	$20 copay, then 80%, up to a limit of 20 visits each plan year	$20 copay, then non-PLUS deductible, then 80%, up to a limit of 20 visits each 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 Customer Service 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.

	PLUS providers	Non-PLUS providers
Circumcision	PLUS deductible, then 100%	Non-PLUS deductible, then 80%

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 Customer Service at least seven calendar days before services start and ask to speak with a case manager. (See page 99 for more information about case management.)

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 37) – 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 (page 74).

Diabetes supplies

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

	Preferred vendors	Non-preferred vendors
✓ **Diabetes supplies**	PLUS deductible, then 100%	Non-PLUS deductible, then 80%

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 2 of this handbook (pages 123-139).

✕ 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 Customer Service 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 29) – Supplies from UniCare preferred vendors are covered at 100% of the allowed amount. Supplies from non-preferred vendors are covered at 80% and you owe 20% coinsurance. Your deductible applies to both types of vendors.

💻 For a list of UniCare preferred vendors, select *Preferred vendors* on the *Members* page of unicarestateplan.com, or call UniCare Customer Service at 800-442-9300 for help.

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

Dialysis

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

	PLUS providers	Non-PLUS providers
Dialysis	PLUS deductible, then 100%	Non-PLUS deductible, then 80%

✕ Restrictions:

- There is no coverage for transportation to dialysis appointments.

Doctor and other health care provider services

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

	PLUS providers	Non-PLUS providers
Primary care office visits ▪ With a Patient-Centered Primary Care PCP (page 89)	$15 copay, then 100%	*Not applicable*
▪ With another PCP	$20 copay, then 100%	$20 copay, then non-PLUS deductible, then 80%
Specialist office visits	$30/60/90 copay, then 100%	$30/60/90 copay, then non-PLUS deductible, then 80%
LiveHealth Online (page 91)	$15 copay, then 100%	*Not applicable*
Inpatient hospital services	PLUS deductible, then 100%	Non-PLUS deductible, then 80%
Emergency treatment	PLUS deductible, then 100%	PLUS deductible, then 100%

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

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

✕ Restrictions:

- 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.

	PLUS providers	Non-PLUS providers
Lab tests for drug screening	PLUS deductible, then 100%	Non-PLUS deductible, then 80%

✕ 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
- UniCare covers the majority of lab tests, including all out-of-network drug screenings. Your behavioral health plan, administered by Beacon Health Options, covers only those drug screenings that are conducted by Beacon's in-network behavioral health providers. You do not need to submit claims to Beacon for screenings conducted by Beacon providers. For information about drug screenings performed by behavioral health providers, see Part 3 of this handbook.

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

	Preferred vendors	Non-preferred vendors
☎ ✓ **Breast pumps**	100%	80%
☎ ✓ **All other DME**	PLUS deductible, then 100%	Non-PLUS deductible, then 80%

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 Customer Service 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 29) – DME and related supplies from UniCare preferred vendors are covered at 100% of the allowed amount. DME and related supplies from non-preferred vendors are covered at 80%, and you owe 20% coinsurance. Your deductible applies to both types of vendors.

💻 For a list of UniCare preferred vendors, select *Preferred vendors* on the *Members* page of unicarestateplan.com, or call UniCare Customer Service at 800-442-9300 for help.

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

Early intervention programs

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.

	PLUS providers	Non-PLUS providers
Early intervention services	100%	100%

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 have the same level of coverage whether you get them from PLUS or non-PLUS providers. But if you're admitted to a Massachusetts hospital from the emergency room, you'll owe the inpatient copay for that hospital's tier.

	PLUS providers	Non-PLUS providers
Hospital emergency rooms	$100 copay, then PLUS deductible, then 100% (copay is waived if admitted to the hospital)	$100 copay, then PLUS deductible, then 100% (copay is waived if admitted to the hospital)
Urgent care centers	$20 copay, then 100%	$20 copay, then 100%
Retail health clinics	$20 copay, then 100%	$20 copay, then 100%
Medical practice office visits	▪ **With a PCP:** $15/20 copay, then 100% ▪ **With a specialist:** $30/60/90 copay, then 100%	▪ **With a PCP:** $20 copay, then non-PLUS deductible, then 80% ▪ **With a specialist:** $30/60/90 copay, then non-PLUS deductible, then 80%

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 7.

Table 7. 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** (such as CVS's MinuteClinic®) 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. As the benefits chart shows, how your visit is billed determines how much you owe.

✕ Restrictions:

- If you are admitted to a Massachusetts hospital from the emergency room, you'll owe the inpatient copay for that hospital's tier.
- Non-emergency services received at an emergency room are covered at the non-emergency benefit level.

☎ **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 Customer Service within 24 hours of, or the next business day after, being admitted.

Enteral therapy

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

	Preferred vendors	Non-preferred vendors
☎ ✓ **Enteral therapy**	PLUS deductible, then 100%	Non-PLUS deductible, then 80%

☎ **Enteral therapy needs preapproval** – Contact UniCare Customer Service at least one business day before services start.

✓ **Use preferred vendors** (page 29) – Enteral therapy from a UniCare preferred vendor is covered at 100% of the allowed amount. From non-preferred vendors, enteral therapy is covered at 80% and you owe 20% coinsurance. Your deductible applies to both types of vendors.

💻 For a list of UniCare preferred vendors, select *Preferred vendors* on the *Members* page of unicarestateplan.com, or call UniCare Customer Service at 800-442-9300 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.

	PLUS providers	Non-PLUS providers
Routine eye exams Refraction/glaucoma testing	$30/60/90 copay, then 100%; covered once every 24 months	$30/60/90 copay, then 80%; covered once every 24 months
Eye care office visits When medically necessary	$30/60/90 copay, then 100%	$30/60/90 copay, then non-PLUS deductible, then 80%

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.

	PLUS providers	Non-PLUS providers
Eyeglasses and contact lenses	PLUS deductible, then 80%; limited to the initial lenses within six months after an eye injury or cataract surgery	Non-PLUS deductible, then 80%; limited to the initial lenses within six months after an eye injury or cataract surgery

✕ Restrictions:

- Eyeglasses and contact lenses are only covered within six months after an eye injury or cataract surgery. Coverage applies to the initial lenses only.
- There is no coverage for deluxe frames or specialty lenses such as progressive or transitional lenses, tinted lenses, anti-reflective coating or polycarbonate lenses.

Family planning

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

	PLUS providers	Non-PLUS providers
Office visits	100%	100%
Procedures	100%	100%

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

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

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

Fitness club reimbursement

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

	PLUS providers	Non-PLUS providers
Fitness club reimbursement	$100 per family each plan year	$100 per family each plan year

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

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

✕ Restrictions:

- Although any family member may have the fitness membership, the reimbursement is a one-time payment each plan year and is made to the plan enrollee only.
- Fitness clubs are limited to health clubs or gyms that offer cardio and strength-training machines, and other programs for improved physical fitness. Martial arts centers, gymnastics centers, country clubs, beach clubs, sports teams and leagues, 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.

	PLUS providers	Non-PLUS providers
Routine foot care	▪ **With a PCP:** $15/20 copay, then 100% ▪ **With a specialist:** $30/60/90 copay, then 100%	▪ **With a PCP:** $20 copay, then non-PLUS deductible, then 80% ▪ **With a specialist:** $30/60/90 copay, then non-PLUS deductible, then 80%

✕ 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.

	PLUS providers	Non-PLUS providers
Annual exam, with Pap smear	100%	100%
Office visits	▪ **With a PCP:** $15/20 copay, then 100% ▪ **With a specialist:** $30/60/90 copay, then 100%	▪ **With a PCP:** $20 copay, then non-PLUS deductible, then 80% ▪ **With a specialist:** $30/60/90 copay, then non-PLUS deductible, then 80%

Hearing aids

Hearing aids are covered when prescribed by a physician.

	PLUS providers	Non-PLUS providers
Age 21 and under	100%, up to a limit of $2,000 for each impaired ear every 36 months	100%, up to a limit of $2,000 for each impaired ear every 36 months
Age 22 and over	100% of the first $500, then 80% of the next $1,500, up to a limit of $1,700 every 24 months	100% of the first $500, then 80% of the next $1,500, up to a limit of $1,700 every 24 months

✕ Restrictions:

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

	PLUS providers	Non-PLUS providers
Hearing exams	▪ **With a PCP:** $15/20 copay, then 100% ▪ **With a specialist:** $30/60/90 copay, then 100%	▪ **With a PCP:** $20 copay, then non-PLUS deductible, then 80% ▪ **With a specialist:** $30/60/90 copay, then non-PLUS deductible, then 80%
Hearing screenings for newborns	100%	100%

✕ Restrictions:

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

Home health care

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.

	Preferred vendors	Non-preferred vendors
☎ ✓ **Home health care**	PLUS deductible, then 100%	Non-PLUS deductible, then 80%

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 provided by you, a member of your immediate family, or any person who resides in your home. 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.

☎ **Home health care needs preapproval** – Contact UniCare Customer Service at least one business day before services start.

✓ **Use preferred vendors** (page 29) – Home health services from a UniCare preferred vendor are covered at 100% of the allowed amount. From non-preferred vendors, home health services are covered at 80% and you owe 20% coinsurance. Your deductible applies to both types of vendors.

💻 For a list of UniCare preferred vendors, select *Preferred vendors* on the *Members* page of unicarestateplan.com, or call UniCare Customer Service at 800-442-9300 for help.

Home infusion therapy

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

	Preferred vendors	Non-preferred vendors
✓ **Home infusion therapy**	PLUS deductible, then 100%	Non-PLUS deductible, then 80%

✕ Restrictions:

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

✓ **Use preferred vendors** (page 29) – Home infusion therapy from a UniCare preferred vendor is covered at 100% of the allowed amount. From non-preferred vendors, home infusion therapy is covered at 80% and you owe 20% coinsurance. Your deductible applies to both types of vendors.

💻 For a list of UniCare preferred vendors, select *Preferred vendors* on the *Members* page of unicarestateplan.com, or call UniCare Customer Service at 800-442-9300 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 (see page 62). **Palliative care** is focused on relieving pain or other symptoms of illness and improving the quality of life for patients and their families.

	PLUS providers	Non-PLUS providers
Hospice care	PLUS deductible, then 100%	Non-PLUS deductible, then 80%
Bereavement counseling	PLUS deductible, then 80%, up to a limit of $1,500 per family	Non-PLUS deductible, then 80%, up to a limit of $1,500 per family

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 bereavement services may be available under the behavioral health benefit (see pages 141-168).
- ■ Hospice care benefits for members in skilled nursing facilities are limited to supplemental skilled nursing services and social services. Services normally provided by skilled nursing facilities – such as physical therapy, counseling, and DME – are not covered as hospice care.
- ■ 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 have an inpatient stay at an inpatient facility. 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).

	PLUS providers	Non-PLUS providers
At a hospital or rehab facility		
☎ **Inpatient services (semi-private room)**	$275/500/1,500 quarterly copay, then PLUS deductible, then 100%	$500 quarterly copay, then non-PLUS deductible, then 80%
☎ **Inpatient services (private room, if medically necessary)**	▪ **First 90 days:** $275/500/1,500 quarterly copay, then PLUS deductible, then 100% ▪ **After 90th day:** 100% of the semi-private room rate	▪ **First 90 days:** $500 quarterly copay, then non-PLUS deductible, then 80% ▪ **After 90th day:** 80% of the semi-private room rate
☎ **Inpatient services for select complex inpatient procedures and neonatal ICUs (page 57)**	▪ **At a designated hospital:** $275 quarterly copay, then PLUS deductible, then 100% ▪ **At a non-designated hospital:** $275/500/1,500 quarterly copay, then PLUS deductible, then 100%	▪ **At a designated hospital:** $275 quarterly copay, then PLUS deductible, then 100% ▪ **At a non-designated hospital:** $500 quarterly copay, then non-PLUS deductible, then 80%
At a skilled nursing facility or long-term care facility		
☎ **Inpatient services**	PLUS deductible, then 80%, up to a limit of 45 days each plan year	PLUS deductible, then 80%, up to a limit of 45 days each plan year

Table 8 lists examples of the services and supplies covered under the benefit for inpatient care.

Table 8. 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.
- The Plan does not cover **custodial care**, 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.
- Hospice care benefits for members in skilled nursing facilities are limited to supplemental skilled nursing services and social services. Services normally provided by skilled nursing facilities – such as physical therapy, counseling, and DME – are not covered as hospice care.
- Private rooms are covered only if medically necessary.
- There is no coverage for private duty nursing in an inpatient facility.
- The Plan does not pay for donated blood.
- Convenience items such as telephone, radio and television are not covered.
- Services that are considered experimental or investigational are not covered.
- Devices that are not directly involved in the surgery, such as artificial limbs, artificial eyes or hearing aids may be covered under a different benefit, such as prosthetics.
- There is no coverage for charges for services that are not medically necessary.

☎ Notify UniCare about any hospital stay – You (or someone acting for you) must notify UniCare Customer Service 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 98-99 for a description of how UniCare reviews inpatient admissions.

Complex inpatient procedures and neonatal ICUs

For complex inpatient procedures and neonatal ICU care, significant clinical experience is likely to enhance the quality of care. The Plan has identified certain hospitals with significant experience and patient volume in each of these procedures. When these procedures (listed in Table 9) are performed at the designated hospitals, services are covered at the PLUS Tier 1 copay.

Table 9. Designated Hospitals for Complex Inpatient Procedures and Neonatal ICUs

	Beth Israel Deaconess Medical Center	Boston Medical Center	Brigham and Women's Hospital	Lahey Hospital & Medical Center	Tufts Medical Center	UMass Memorial Medical Center
Abdominal aortic aneurysm repair	■	■	■	■		■
Cardiac valve procedures	■		■		■	■
Esophagectomy	■	■	■	■		■
Neonatal ICUs	■		■			■
Pancreatic resection	■	■	■	■	■	■

The listed procedures have been designated by the Leapfrog Group[1] as complex procedures that studies show are most safely performed at hospitals that:

1. Have significant experience in performing the procedure
2. Demonstrate specific clinical practices established by the Leapfrog Group

Other procedures designated by the Leapfrog Group as complex procedures are safely performed at multiple PLUS Tier 1 hospitals, so there is no need to add additional hospitals for these procedures.

1 The Leapfrog Group is a nationwide coalition of large employers and payers pushing for improvements in the quality and safety of American health care.

Immunizations (vaccines)

Immunizations (vaccines) recommended by the U.S. Preventive Services Task Force are covered at 100%, according to the preventive care schedule (pages 73-76).

	PLUS providers	Non-PLUS providers
At a doctor's office	100% (you may also owe an office visit copay)	100% (you may also owe the non-PLUS deductible and an office visit copay)
At a travel clinic	100%	100%
At a pharmacy	100% (you may have to pay up front and submit the claim yourself)	100% (you may have to pay up front and submit the claim yourself)

✕ Restrictions:

- Unless you are pregnant, there is no coverage for blood tests (titers) to determine if you need an immunization. See restriction #46 on page 81.
- 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.

	PLUS providers	Non-PLUS providers
Inpatient	PLUS deductible, then 100%	Non-PLUS deductible, then 80%
Outpatient	PLUS deductible, then 100%	Non-PLUS deductible, then 80%
Emergency room	PLUS deductible, then 100%	PLUS deductible, then 100%
Preventive lab work	100%, according to the preventive care schedule (pages 73-76)	

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 55-57).

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 (not otherwise specified)

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

	PLUS providers	Non-PLUS providers
Covered medical services (not otherwise specified)	PLUS deductible, then 80%	Non-PLUS deductible, then 80%

Neuropsychological (neuropsych) testing

The Plan covers neuropsych testing when the testing is for a condition such as head injury, stroke or dementia and when it is performed by a medical provider.

Beacon Health Options covers neuropsych testing when it is for a condition like depression that is performed by behavioral health providers, including psychiatrists. For more information, 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).

Nutritional counseling

Nutritional counseling services, provided by a registered dietician, are covered under the following circumstances:

- ❑ Adults at high risk for cardiovascular disease are covered for up to three visits a year under the preventive benefit (page 74).
- ❑ Children under 18 are covered as part of treatment for cleft lip or cleft palate (page 37).
- ❑ Members with diabetes are covered under the benefit for diabetes care (page 40).
- ❑ Members with certain eating disorders are covered for ongoing counseling. Note that other charges for the treatment of eating disorders may be covered under the behavioral health benefit (see Part 3 of this handbook).

Occupational therapy

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

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

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

	PLUS providers	Non-PLUS providers
☎ **Occupational therapy**	$20 copay, then 100%	$20 copay, then non-PLUS deductible, then 100%

✕ Restrictions:

- Group occupational therapy is not covered.

☎ **Occupational therapy needs preapproval** – Contact UniCare Customer Service at least one business day before services start.

Outpatient hospital services (not otherwise specified)

☞ **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.

	PLUS providers	Non-PLUS providers
Outpatient hospital services	PLUS deductible, then 100%	Non-PLUS deductible, then 80%

Oxygen

Oxygen and its administration are covered.

	Preferred vendors	Non-preferred vendors
✓ **Oxygen**	PLUS deductible, then 100%	Non-PLUS deductible, then 80%

✗ Restrictions:

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

✓ **Use preferred vendors** (page 29) – Supplies from UniCare preferred vendors are covered at 100% of the allowed amount. From non-preferred vendors, supplies are covered at 80% and you owe 20% coinsurance. Your deductible applies to both types of vendors.

For a list of UniCare preferred vendors, select *Preferred vendors* on the *Members* page of unicarestateplan.com, or call UniCare Customer Service at 800-442-9300 for help.

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

Palliative care

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

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

Personal Emergency Response Systems (PERS)

Installation and rental of personal emergency response systems (PERS) are covered when:

- ❑ The PERS is provided by a hospital
- ❑ You are homebound
- ❑ 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

	PLUS providers	Non-PLUS providers
Installation	PLUS deductible, then 80%, up to a limit of $50	PLUS deductible, then 80%, up to a limit of $50
Rental fee	PLUS deductible, then 80%, up to a limit of $40 each month	PLUS deductible, then 80%, up to a limit of $40 each 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.

	PLUS providers	Non-PLUS providers
☎ **Physical therapy**	$20 copay, then 100%	$20 copay, then non-PLUS deductible, then 100%

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 Customer Service at least one business day before services start.

Prescription drugs

Benefits for most prescription drugs are administered by CVS Caremark. See Part 2 (pages 123-139) 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 15-19.

Preventive care

The Plan covers preventive or routine office visits, physical examinations 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%, without any copays, coinsurance or deductible. Preventive exams are covered according to the schedule issued by Massachusetts Health Quality Partners.

The schedule and guidelines for covered preventive services appears on pages 73-76.

	PLUS providers	Non-PLUS providers
Preventive care	100%	100%

✕ Restrictions:

- Not all preventive health care services, screenings, tests and vaccines are recommended for everyone. You and your doctor should decide what care is most 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 owe a copay, deductible and/or coinsurance 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.

	PLUS providers	Non-PLUS providers
☎ **Private duty nursing**	PLUS deductible, then 80%, up to a limit of $8,000 each plan year	Non-PLUS deductible, then 80%, up to a limit of $8,000 each 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 provided by you, a member of your immediate family or any person who resides in your home. 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.

☎ **Private duty nursing needs preapproval** – Contact UniCare Customer Service 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.

	PLUS providers	Non-PLUS providers
Breast prosthetics	PLUS deductible, then 100%	Non-PLUS deductible, then 100%
Orthopedic shoe with attached brace	PLUS deductible, then 100%	Non-PLUS deductible, then 100%
All other prosthetics and orthotics (including mastectomy bras)	PLUS deductible, then 80%	Non-PLUS deductible, then 80%

✕ 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.

	PLUS providers	Non-PLUS providers
☎ **Radiation therapy**	PLUS deductible, then 100%	Non-PLUS deductible, then 80%

☎ **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.

	PLUS providers	Non-PLUS providers
Emergency room Including high-tech imaging	PLUS deductible, then 100%	PLUS deductible, then 100%
Inpatient Including high-tech imaging	PLUS deductible, then 100%	Non-PLUS deductible, then 80%
☎ **Outpatient high-tech imaging** Such as MRIs, CT scans and PET scans	$100 copay, then PLUS deductible, then 100% (limit of one copay a day)	$100 copay, then non-PLUS deductible, then 80% (limit of one copay a day)
All other outpatient radiology Such as X-rays	PLUS deductible, then 100%	Non-PLUS deductible, then 80%

☎ **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 55-57).

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 page 46 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 55-57).

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.

	PLUS providers	Non-PLUS providers
☎ **Sleep studies**	PLUS deductible, then 100%	Non-PLUS deductible, then 80%

☎ **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.

	PLUS providers	Non-PLUS providers
Speech therapy	100%, up to a limit of 20 visits each plan year	Non-PLUS deductible, then 80%, up to a limit of 20 visits each plan year

Covered speech therapy services include:

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

✕ Restrictions:

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

Surgery

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

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

	PLUS providers	Non-PLUS providers
☎ **Inpatient surgery** You'll also owe the inpatient hospital copay (page 55)	PLUS deductible, then 100%	Non-PLUS deductible, then 80%
☎ **Outpatient surgery at a hospital-owned location**	$110/110/250 quarterly copay, then PLUS deductible, then 100%	$110 quarterly copay, then non-PLUS deductible, then 80%
☎ **Outpatient surgery at a non-hospital-owned location** Such as a doctor's office or an ambulatory surgery center	PLUS deductible, then 100%	Non-PLUS deductible, then 80%

Charges for the following services qualify as covered surgical charges:

1. Medically necessary surgical procedures when performed on an inpatient or outpatient basis (hospital, physician's office or ambulatory surgery center)
2. Services of one **assistant surgeon** when:
   - ❑ Medically necessary
   - ❑ The assistant surgeon is a physician trained in a surgical specialty related to the procedure and is not a fellow, resident or intern in training, and
   - ❑ The assistant surgeon serves as the first assistant surgeon to the primary surgeon during a surgical procedure

3. Reconstructive breast surgery for all stages of mastectomy, including:
   - ❑ All stages of breast reconstruction
   - ❑ Reconstruction of the other breast to produce a symmetrical appearance
   - ❑ Coverage for prosthetics and treatment of physical complications, including lymphedemas

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

✕ Restrictions:

- Coverage for **reconstructive and restorative surgery** – defined as surgery intended to improve or restore bodily function or to correct a functional physical impairment that has been caused by either a congenital anomaly or a previous surgical procedure or disease – is limited to the following:
  - Correction of a functional physical impairment due to previous surgery or disease
  - Reconstruction of defects resulting from surgical removal of an organ or body part for the treatment of cancer. Such restoration must be within five years of the removal surgery.
  - Correction of a congenital birth defect that causes functional impairment for a minor dependent child
- 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 lypodystrophy and the initial surgical procedure to correct appearance that has been damaged by an accidental injury.
- Assistant surgeon services are limited, as follows:
  - 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.

☎ **Some surgeries need preapproval** – Notify UniCare Customer Service at least seven days before having any of the surgical procedures listed on page 19.

Tobacco cessation counseling

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

	PLUS providers	Non-PLUS providers
Tobacco cessation counseling	100%, up to 300 minutes each plan year	100%, up to 300 minutes each plan year

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

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

Tobacco cessation counseling can be billed directly to UniCare. However, if your provider is unable to bill the Plan directly, or does not accept insurance, you can submit your claim yourself. Download a claim form at unicarestateplan.com or call UniCare Customer Service 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 2 of this handbook for details.

✕ Restrictions:

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

Transplants

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

	PLUS providers	Non-PLUS providers
☎ At a Quality Center or Designated Hospital for transplants	$275/500/1,500 quarterly copay, then PLUS deductible, then 100%	$500 quarterly copay, then non-PLUS deductible, then 80%
☎ At another hospital	$275/500/1,500 quarterly copay, then PLUS deductible, then 80%	$500 quarterly copay, then non-PLUS deductible, then 80%

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

- ❑ Review your ongoing needs
- ❑ Help to coordinate services while you are awaiting a transplant
- ❑ Help you and your family optimize Plan benefits

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

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

- ❑ Call UniCare Customer Service at 800-442-9300 and ask to speak with a case manager. (See page 99 for more information about case management.)
- ❑ You do not need to notify UniCare for cornea transplants.

Human organ donor services

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

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

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

	PLUS providers	Non-PLUS providers
Travel clinic office visits	100%	100%
Immunizations at travel clinics	100%	100%

✕ Restrictions:

- Unless you are pregnant, there is no coverage for blood tests (titers) to determine if you need an immunization. See restriction #46 on page 81.

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 page 46 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 page 46 for information about the different types of walk-in clinics.

Wigs

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

	PLUS providers	Non-PLUS providers
Wigs	80%	80%

✕ Restrictions:

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

Schedule of preventive services

The Plan covers preventive or routine level office visits, physical examinations and other related preventive services listed in Table 10. Covered preventive services include those services recommended by the U.S. Preventive Services Task Force as part of the Patient Protection and Affordable Care Act (PPACA), the health care reform legislation that was passed in March 2010. Preventive exams are covered according to the schedule issued by Massachusetts Health Quality Partners.

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

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

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

Table 10. Preventive Care Schedule

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

Table 10. Preventive Care Schedule *(continued)*

Preventive Service	Men	Women	Children	Age	Frequency
Cervical cancer screening (Pap smear)		■	■		Every 12 months
Chlamydia screening		■	■		
Cholesterol abnormalities screening	■	■			Every 12 months
Colorectal cancer screening (including colonoscopies, fecal occult blood testing, and other related services and tests) Colonoscopies for members under 50 are covered under limited circumstances (see #16 on page 78) ☎ Virtual colonoscopies require preapproval	■	■		50 and older	▪ Every 5 years (60 months) ▪ Every 12 months for fecal occult blood test
Depression screening	■	■	■		Covered as part of your preventive exam
Diabetes screening (Type 2 and gestational)	■	■			
Diet and physical activity counseling in primary care to promote healthy diet, in adults at high risk for cardiovascular disease (see #60 on page 83)	■	■			Covered as part of your preventive exam
Fall prevention for at-risk community-dwelling adults (Vitamin D counseling and/or physical therapy)	■	■		65 and over	Counseling is covered as part of your preventive exam
Fluoride varnish for children, starting at the age of primary tooth eruption			■	Up to age 5	
Folic acid supplementation		■			Subject to the Plan's pharmacy benefit
Gonorrhea screening		■			Every 12 months
Gonorrhea prophylactic medication (newborns)			■		
Gynecological examination		■			Every 12 months
Hearing loss screening (newborns)			■		
Hepatitis B screening	■	■	■		

Table 10. Preventive Care Schedule *(continued)*

Preventive Service	Men	Women	Children	Age	Frequency
Hepatitis C screening	■	■	■		
HIV screening	■	■	■		
Human papillomavirus (HPV) DNA test		■		30 and older	Every 3 years for women with normal cytology results
Hypothyroidism screening (newborns)			■		
Immunizations	■	■	■		
Intimate partner violence screening (women of childbearing age)		■			Covered as part of your preventive exam
Iron deficiency anemia prevention (at risk 6- to 12-month-old babies)			■		
Lead screening (children)			■		
☎ Lung cancer screening (CT scan) for adults who have smoked	■	■		55-80 years	Every 12 months
Obesity screening	■	■	■		Covered as part of your preventive exam
Osteoporosis screening (bone density testing)		■		40 and older	Every 2 years
Phenylketonuria (PKU) screening (newborn)			■		
Preeclampsia prevention (aspirin) counseling (during pregnancy)		■			Covered as part of your preventive exam
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

Table 10. Preventive Care Schedule *(continued)*

Preventive Service	Men	Women	Children	Age	Frequency
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 – Covered as part of your preventive exam ▪ PSA test – Every 12 months
Rh incompatibility screening (during pregnancy)		■			
Sexually transmitted infections counseling	■	■	■		Covered as part of your preventive exam
Sickle cell disease screening (newborns)			■		
Skin cancer behavioral counseling	■	■	■	10-24 years	Covered as part of your preventive exam
Syphilis screening	■	■	■		
Tobacco use counseling and interventions	■	■	■		▪ Counseling – Covered as part of your preventive exam ▪ Drugs and deterrents – Subject to the Plan's pharmacy benefit
Visual impairment screening	■	■	■		Covered as part of your preventive exam

Additional covered preventive 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)
	■	■			When performed as part of your preventive exam

4: Coverage that is excluded or limited

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

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

1. **Acne-related services**, such as the removal of acne cysts, injections to raise acne scars, cosmetic surgery, dermabrasion or other procedures to plane the skin, are not covered. Benefits are provided for outpatient medical care to diagnose or treat the underlying condition identified as causing the acne.
2. **Acupuncture** is not covered.
3. **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 for ambulance calls that are then refused.
4. **Anesthesia** for behavioral health services is only covered for electroconvulsive therapy (ECT). Note that other charges associated with ECT are covered under the behavioral health benefits described in Part 3 (pages 141-168).
5. **Arch supports**, such as Dr. Scholl's inserts, are not covered.
6. **Assistant surgeon services** are limited, as follows:
   - ❑ 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.
7. **Athletic trainers** – There is no coverage for any services provided by athletic trainers.
8. **Beds** – There is no coverage for non-hospital beds or orthopedic mattresses.

9. **Behavioral health conditions** – With the exception of primary care visits associated with a behavioral health diagnosis, there is no coverage for the diagnosis, treatment or management of mental health/substance use disorder conditions by medical (non-behavioral health) providers. See Part 3 (pages 141-168) for coverage details when these services are provided by behavioral health providers (including psychiatrists).
10. **Blood** – The Plan does not pay for donated blood.
11. **Blood pressure cuffs (sphygmomanometers)** are not covered.
12. **Cardiac rehab programs** are only covered if started within six months of a cardiac event.
13. **Chair cars/vans** – Transportation in chair cars or vans is not covered.
14. **Clinical trials for treatments other than cancer** – Any clinical research trial other than a qualified clinical trial for the treatment of cancer (page 38) is not covered.
15. **Cognitive rehabilitation or therapy** is defined as treatment to restore function or minimize effects of cognitive deficits including, but not limited to, those related to thinking, learning and memory. There is no coverage for cognitive rehabilitation or therapy.
16. **Colonoscopies** – Screening colonoscopies for people under 50 are covered as a preventive service only under limited circumstances, based on clinical review of family and personal history.
17. **Computer-assisted communications devices** are not covered.
18. **Convenience items** – Charges for convenience items used during a hospital stay, such as telephone and television, are not covered.
19. **Cosmetic services** are services performed mainly for the purpose of improving appearance. These services do not restore bodily function or correct functional impairment. There is no coverage for cosmetic procedures or services, with the exception of:
    - ❑ Treatment for HIV-associated lypodystrophy
    - ❑ 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.
20. **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. There is no coverage for custodial care.
21. **Dental care** – Because the Plan is a medical plan, not a dental plan, there are no benefits for dental care. However, medical services that include treatment related to dental care are covered in certain situations. See "Dental services" on page 40 for details.
22. **Dentures, dental prosthetics and related surgery** are not covered.
23. **Driving evaluations** are not covered.

24. **Drugs**
    - ❑ **Drugs prescribed off-label** – Off-label use of a prescription drug (using a drug for a purpose other than that approved by the Food and Drug Administration) is not covered, unless the use meets the Plan's definition of medical necessity or the drug is specifically designated as covered by the Plan.
    - ❑ **Over-the-counter drugs** are not generally covered; they are 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.
    - ❑ **Non-oncology infused drugs** are dispensed by the prescription drug plan and require prior review (see Part 2 of this handbook).
    - ❑ **Specialty drugs** – Some specialty drugs are covered by UniCare 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). To learn more about the preapproval process, see pages 15-19.

      Other self- or office-administered specialty drugs are covered and dispensed under the prescription drug plan (Part 2 of this handbook). Specialty drugs (specialty medications) are defined as certain pharmaceutical and/or biotech or biological drugs (including "biosimilars" or "follow-on biologics") 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.

25. **Duplicate services** – Duplicate or redundant services are not covered. A service or supply is considered redundant when the same service or supply is being provided or being used, at the same time, to treat the condition for which it is ordered.

26. **Durable medical equipment (DME)** – Coverage is limited to medically necessary equipment. Types of equipment that are not covered under the benefit for DME 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., 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

27. **Ear molds** are not covered, except when needed for hearing aids for members age 21 and under.

28. **EKG (electrocardiogram)** done solely for the purpose of screening or prevention is not covered.
29. **Email consultations** are not covered (also see restriction #83).
30. **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.
31. **Equipment transportation and set-up** – There is no coverage for costs associated with transporting and setting up equipment, such as portable X-ray equipment.
32. **Exercise/recreational equipment** – There is no coverage for equipment intended for athletic or recreational use, (e.g., exercise equipment, wheelchairs for sports).
33. **Experimental or investigational services or supplies** – There is 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 has been tried after others have failed, does not make it medically necessary.
34. **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.
35. **Family members/household residents** – There is no coverage for services or supplies provided by you, a member of your immediate family, or any person who resides in your home. 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.
36. **Fees for non-medical services** – There is no coverage for charges for non-medical services. Non-covered charges include, but are not limited to:
    - ❑ 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
    - ❑ 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)

37. **Fitness reimbursement** – The following restrictions apply to the fitness reimbursement benefit:
    - ❑ Although any family member may have the fitness membership, the reimbursement is a one-time payment each plan year and is made to the plan enrollee only.
    - ❑ Fitness clubs are limited to health clubs or gyms that offer cardio and strength-training machines, and other programs for improved physical fitness. Martial arts centers, gymnastics centers, country clubs, beach clubs, sports teams and leagues, 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.
38. **Free or no-cost services** – There is no coverage for any medical service or supply for which there would have been no charge in the absence of medical insurance.
39. **Government programs** – There is no coverage for any service or supply furnished by, or covered as a benefit under, a program of any government or its subdivisions or agencies, except for the following:
    - ❑ A program established for its civilian employees
    - ❑ Medicare (Title XVIII of the Social Security Act)
    - ❑ Medicaid (any state medical assistance program under Title XIX of the Social Security Act)
    - ❑ A program of hospice care
40. **Group chiropractic care, group occupational therapy and group physical therapy** are not covered.
41. **Hearing aid batteries** are not covered.
42. **Hippotherapy** (therapeutic or rehabilitative horseback riding) is not covered.
43. **Home modifications or environmental controls** – Items intended for environmental control or home modification are not covered (e.g., electronic door openers, air cleaners, dehumidifiers, elevators, ramps, stairway lifts).
44. **Homemaking services** are not covered.
45. **Hospice services at a skilled nursing facility** – Hospice benefits for members in skilled nursing facilities are limited to supplemental skilled nursing services and social services. Services normally provided by skilled nursing facilities – such as physical therapy, counseling, and DME – are not covered as hospice care.
46. **Immunization titers** are lab tests which are performed to determine if a person has had a vaccination. They are covered for pregnant women only.
47. **Incontinence supplies** are not covered.

48. **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.
    - ❑ **Donors** – 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.
    - ❑ **Surrogates** – 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.
49. **Intraocular lenses (IOLs)** – Monofocal intraocular lenses (IOLs) implanted in the eye after the removal of cataracts are covered when you have cataract surgery. There is no coverage for presbyopia-correcting IOLs (IOLs that restore vision in a range of distances). Multifocal IOLs and accommodating IOLs are both types of presbyopia-correcting IOLs and are also not covered.
50. **Language therapy** for learning disabilities such as dyslexia is not covered.
51. **Lift/riser chairs** are not covered.
52. **Long-term maintenance care and long-term therapy** are not covered.
53. **Massage therapy** and any other services provided by a massage therapist or neuromuscular therapist are not covered.
54. **Mastectomy bras** are limited to two bras every two years, unless a change to your prosthetic requires a replacement bra. Supporting documentation is required.
55. **Medical necessity** – There is no coverage for any service or supply that is not medically necessary for the care and treatment of an injury, disease or pregnancy. The only exceptions to this exclusion are:
    - ❑ Routine care of a newborn child provided by a hospital during a hospital stay that starts with birth and while the child's mother is confined in the same hospital
    - ❑ Covered preventive care provided by a hospital or physician (page 73)
    - ❑ A service or supply that qualifies as a covered hospice care service (page 53)

56. **Medical orders** – All covered services and supplies require a medical order from a physician. There is no coverage for any service or supply that has not been recommended and approved by a physician.
57. **Missed appointments** – Charges for missed appointments are not covered.
58. **Molding helmets** and adjustable bands intended to mold the shape of the cranium are not covered.
59. **Non-covered services and associated services** – There is no coverage for facility fees, anesthesia or other services required for the performance of a service that is not covered by the Plan. Non-covered services include those for which there is no benefit and those that the Plan has determined to be not medically necessary.
60. **Nutritional counseling** – Services or counseling must be performed by a registered dietician and are only covered for:
    - ❑ Adults at high risk for cardiovascular disease (limited to three visits a year)
    - ❑ Children under 18 with cleft lip/palate (page 37)
    - ❑ Members with certain eating disorders (see Part 3 of this handbook)
    - ❑ Members with diabetes (page 40)
61. **Nutritional supplements (oral)** – There is no coverage for nutritional supplements that are administered by mouth, including:
    - ❑ Dietary and food supplements that are administered orally and related supplies
    - ❑ Nutritional supplements to boost caloric or protein intake, including sport shakes, puddings and electrolyte supplements
62. **Orthodontic treatment**, including treatment done in preparation for surgery, is not covered.
63. **Orthopedic mattresses** are not covered.
64. **Orthotics** – There is no coverage for temporary or trial orthotics, video tape gait analysis, diagnostic scanning, or arch supports.
65. **Oxygen equipment for travel** – There is no coverage for oxygen equipment required for use on an airplane or other means of travel.
66. **Personal items** – 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).

67. **Physical therapy**
    - ❑ 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.
68. **Private duty nursing** in an acute care hospital or any other inpatient facility is not covered.
69. **Programs with multiple services** – Programs that provide multiple services but that bill at a single, non-itemized rate (for example, a daily fee for a full-day rehab program) are not covered. Itemized bills are always required.
70. **Reiki** – There is no coverage for Reiki, a hands-on energy-based therapy.
71. **Religious facilities** – Services received at non-medical religious facilities are not covered.
72. **Respite care** is limited to a total of five days. Respite care is covered in a hospital, a skilled nursing facility, a nursing home or in the home.
73. **Routine screenings** are not covered except according to the preventive care schedule (pages 73-76).
74. **Schools** – There is no coverage for any services or treatments required under law to be provided by the school system for a child.
75. **Sensory integration therapy** is not covered.
76. **Serious preventable adverse events** – Costs associated with serious preventable adverse health care events are not covered, in accordance with Department of Public Health (DPH) regulations. Massachusetts providers are not permitted to bill members for designated serious reportable health care events.

    💻 For more information on this policy and a list of these events, visit unicarestateplan.com.
77. **Shingles vaccine** – The shingles vaccine is covered only for members over age 50.
78. **Shipping costs**, such as the cost of shipping eggs or sperm between fertility clinics, are not covered.
79. **Shoes** – There is no coverage for shoes, including special shoes purchased to accommodate orthotics or to wear after foot surgery, with the exception of:
    - ❑ Therapeutic shoes for the prevention of complications associated with diabetes (limited to one pair each year)
    - ❑ Orthopedic shoes that attach directly to a brace
80. **Stairway lifts and stair ramps** are not covered.

81. **Storage for blood/bodily fluids** – Storage of autologous blood donations or other bodily fluids or specimens is not covered, except when done in conjunction with use in a scheduled procedure that is covered.
82. **Surface electromyography (SEMG)** is not covered.
83. **Telehealth services** from any program other than LiveHealth Online are not covered. There is no coverage for audio-only telephone consultations, email consultations, or services obtained from websites.
84. **Telephone consultations** are not covered (also see restriction #83).
85. **Thermal therapy** – Any type of hot or cold thermal therapy device is not covered.
86. **Third parties** – There is no coverage for any medical supply or service (such as a court-ordered test or an insurance physical) that is required by a third party but is not otherwise medically necessary. Other examples of a third party are an employer, an insurance company, a school, a court or a sober living facility.
87. **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.
88. **Tobacco cessation counseling** is limited to 300 minutes each plan year. Counseling is also covered as part of your preventive exam.
89. **Transportation** to medical appointments, including to dialysis treatment, is not covered.
90. **Travel time** – There's no coverage for travel time to or from appointments for medical care.
91. **Vision correction** – 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).
92. **Vision therapy** is not covered.
93. **Voice therapy** is not covered.
94. **Web-based services** – There is no coverage for consultations or services obtained from websites except through LiveHealth Online (also see restriction #83).
95. **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.
    - ❑ **Residential inpatient weight loss programs** are not covered.
    - ❑ **Membership fees and food items** used to participate in a commercial weight loss program are not covered.

96. **Wheelchair transit systems** – There is no coverage for transit systems used to secure wheelchairs in moving vehicles.
97. **Wigs** are not covered for anything other than the replacement of hair loss resulting from treatment of any form of cancer or leukemia.
98. **Worker's compensation** – There is no coverage for any service or supply furnished for an occupational injury or disease for which a person is entitled to benefits under a workers' compensation law or similar law. **Occupational injury or disease** is an injury or disease that arises out of and in the course of employment for wage or profit.
99. **Worksite evaluations** performed by a physical therapist to evaluate a member's ability to return to work are not covered.
100. **X-ray equipment (portable)** – There is no coverage for costs associated with transporting and setting up portable X-ray equipment.

5: About your plan and coverage

How to use your plan wisely

Table 11 lists tips to help you get the highest level of benefits and avoid paying more than you need to for your medical care.

For a description of the different kinds of providers and facilities mentioned in Table 11, see "Types of health care providers" on pages 89-92.

Table 11. How to Get the Most Out of PLUS

Always use PLUS providers…		See pages
Your benefits are highest – and your member costs are lowest – when you use PLUS providers for your care	PLUS providers are: ▪ All physicians and hospitals in Massachusetts ▪ Physicians and hospitals in the UniCare provider network in other states ▪ Preferred vendors ▪ Specialized health facilities that contract with UniCare	89-92
When you use PLUS specialized health facilities	Specialized health facilities that have a contract with UniCare are PLUS providers and are covered at 100%. Otherwise, these facilities are covered at 80%, so you'll owe 20% coinsurance.	92
✓ **When you use PLUS 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.	29
Remember: Sometimes, you need preapproval…		**See pages**
☎ **Get services preapproved when you need to**	Don't forget 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.	15-19

Table 11. How to Get the Most Out of PLUS *(continued)*

When you get medical care in Massachusetts…		See pages
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.	89
Use Tier 1 or Tier 2 specialists	Your copays are lower when you use specialists who are Tier 1 or Tier 2.	42-43, 93-94
When you need hospital care, use a Tier 1 or Tier 2 hospital	Your copays are lower at Tier 1 and Tier 2 hospitals in Massachusetts.	90, 176
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.	46-47, 90
Have outpatient surgery at an ambulatory surgery center	There's no copay when you have outpatient surgery at an independent ambulatory surgery center (not run by a hospital). If the center is a PLUS provider, you won't have any coinsurance either.	68-69, 92
Avoid getting balance billed outside of Massachusetts…		**See pages**
Use PLUS providers when you get care at home	Always use PLUS providers in the state where you live (your home state). PLUS providers won't balance bill you for charges over the Plan's allowed amount.	89
Use Travel Access providers when you're away from home	If you're traveling outside your home state and need urgent care, go to a UniCare Travel Access provider to avoid unexpected charges. (If you're visiting Massachusetts, you're free to use any provider.)	92
Make sure your out-of-state student dependent uses Travel Access providers	Covered students who go to school outside of your home state (or Massachusetts) should use Travel Access providers when they need urgent care. Make sure they get any non-urgent care – including annual checkups – in your home state.	92
Take advantage of what PLUS has to offer…		**See pages**
Use the SmartShopper program and get cash back	**SmartShopper** lets you compare costs for common procedures at Massachusetts facilities. You can earn a cash reward of up to $500 when you use a cost-effective provider.	115
Get $100 for your fitness club membership	We'll reimburse you for up to $100 of your fitness club membership costs.	50
Video visit with a doctor through LiveHealth Online	From your computer or mobile device, you can reach a doctor anytime, day or night, for a $15 copay.	91

Types of health care providers

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

💻 To find health care providers, select *Look for health care providers* on the *Members* page at unicarestateplan.com, or call UniCare Customer Service at 800-442-9300 for help.

PLUS providers

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

- ❑ All physicians and hospitals in Massachusetts
- ❑ Physicians and hospitals in other states that are in the UniCare provider network
- ❑ Preferred vendors
- ❑ Specialized health facilities, such as dialysis centers, that contract with UniCare (page 92)

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 PLUS 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 in Massachusetts.

PLUS members who live in Connecticut, Maine, New Hampshire or Rhode Island can see PLUS specialists in their home state for a $60 copay.

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 55-57 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** (such as CVS's MinuteClinic®) 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 46-47 for details.

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

- Durable medical equipment (DME)
- Medical/diabetes 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% and you will owe the 20% coinsurance. If you live outside of Massachusetts, non-preferred vendors can balance bill you for charges over the allowed amount. (Note that your deductible may also apply, no matter which type of vendor you use.)

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

☞ **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. You'll have the highest benefit level when you use specialized health facilities that are PLUS providers (those that are contracted with UniCare).

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.

Network providers and Travel Access providers

Network providers are non-Massachusetts PLUS providers – such as doctors, hospitals, and health facilities – who have contracted with UniCare to accept the Plan's allowed amount. If you live in Connecticut, Maine, New Hampshire or Rhode Island, use these PLUS providers in your home state because they won't balance bill you for charges over UniCare's allowed amount (the maximum amount that the Plan pays for covered services).

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

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

> **Behavioral health services** – For mental health and substance use disorder services, you must use a provider in the Beacon Health Options network to avoid getting balance billed. These benefits are administered by Beacon, not by UniCare. See Part 3 (pages 141-168) 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
- PCPs participating in the Patient-Centered Primary Care program
- Urgent care centers
- Retail health clinics
- Preferred vendors
- Specialized health facilities
- Travel Access providers

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

About physician tiering

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

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

***Tier 1 (Excellent)

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

**Tier 2 (Good)

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

*Tier 3 (Standard)

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

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

Also, for a variety of reasons, certain specialists don't have enough data available to allow us to assess either their quality or cost efficiency according to our procedures. In our 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 all 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 at 800-442-9300 to request materials.

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

How to find a specialist's tier

💻 To find out which tier a specialist is in, select *Find a doctor* on the *Members* page at unicarestateplan.com. You can also call UniCare at 800-442-9300 for help.

How UniCare reimburses providers

The Plan routinely reimburses providers on a fee-for-service basis. As various models of health care reform are put in place, as anticipated by legislation in Massachusetts, the Plan may engage certain providers in shared savings and loss arrangements where providers receive additional payments for meeting quality and cost targets. 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 Customer Service at 800-442-9300 to request a form.

> **Claims for prescription drug or behavioral health services** – These claims must be submitted directly to the administrator of those services. For prescription drug claims, see Part 2 (pages 123-139). For mental health, substance use disorder and EAP claims, see Part 3 (pages 141-168).

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 and behavioral health services are also excluded because UniCare does not administer those benefits.

About claim reviews

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

Reviews for fraud and other inappropriate activity

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

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 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 or behavioral health services** – These appeals must be filed with the administrator of those services. For prescription drug appeals, see Part 2 (pages 123-139). For mental health, substance use disorder and EAP appeals, see Part 3 (pages 141-168).

About the review process for preapprovals

UniCare reviews certain medical services and inpatient admissions to make sure they are eligible for benefits. A list of everything that needs to be reviewed appears on page 15-19.

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.

> 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.

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.

Getting support for serious medical issues

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

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

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

6: About enrollment and membership

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

Free or low-cost health coverage for children and families

If you are eligible for health coverage from your employer but are unable to afford the premiums, your state may have a premium assistance program to help pay for coverage. For more information, see Appendix 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 or adoption
- **Foster children ages 19-26:** photocopy of proof of placement letter or court order
- **Spouses:** copy of certified marriage certificate

When coverage begins

Coverage under the Plan starts as follows:

For new employees

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

For persons applying during an annual enrollment period

Coverage begins each year on July 1.

For spouses and dependents

Coverage begins on the later of:

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

For surviving spouses

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

When coverage ends for enrollees

Your coverage ends on the earliest of:

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

When coverage ends for dependents

A dependent's coverage ends on the earliest of:

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

Duplicate coverage

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

Special enrollment condition

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

Continuing coverage upon termination of employment

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

Continuing health coverage for survivors

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

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

Coverage will end on the earliest of:

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

Option to continue coverage for dependents age 26 and over

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

Option to continue coverage after a change in marital status

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

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

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

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

Group health continuation coverage under COBRA

This notice explains 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 Commonwealth's Health Connector Authority, or for employees in other states, through a Health Insurance Marketplace where available. The GIC has no involvement in conversion programs and only very limited involvement in Health Connector programs. You pay the premium to the plan sponsor for the coverage. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA 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, ext. 1 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration 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

7: How to get more information

Who to contact (and for what)

For questions about your medical plan	
UniCare State Indemnity Plan Customer Service Center P.O. Box 9016 Andover, MA 01810-0916 800-442-9300 (toll free) TTY: 711 contact.us@anthem.com unicarestateplan.com	▪ What your benefits are for a particular medical service or procedure ▪ The status of (or a question about) a medical claim ▪ How to find a doctor, hospital or other medical provider ▪ Information in "Your Medical Plan" (Part 1 of this handbook)
For questions about your prescription drug plan	
CVS Caremark 877-876-7214 (toll free) TTY: 800-238-0756 caremark.com	▪ What your benefit is for a prescription drug ▪ The status of (or a question about) a prescription drug claim ▪ Where to get prescriptions filled ▪ Which drugs are covered ▪ Information in "Your Prescription Drug Plan" (Part 2 of this handbook)
For questions about your behavioral health plan	
Beacon Health Options 855-750-8980 (toll free) TTY: 711 beaconhealthoptions.com/gic	▪ What your benefits are for mental health services ▪ What your benefits are for substance use disorder services ▪ What your benefits are for the Enrollee Assistance Program (EAP) ▪ The status of (or a question about) a mental health, substance use disorder or EAP claim ▪ Information in "Your Behavioral Health Plan" (Part 3 of this handbook)
For general health questions after hours (not about plan benefits or coverage)	
24/7 NurseLine 800-424-8814 (toll free) Select the NurseLine option	▪ How to prepare for an upcoming medical procedure ▪ What side effects are possible from your medication ▪ Whether to go to an urgent care center or call your doctor ▪ See page 115 for more information

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.

Contacting the UniCare Customer Service Center

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

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

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

You can use our automated phone line (800-442-9300) to get information about your claims at any time. You can also set up a user account that will let you access your claims online (page 114).

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

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

- ❑ Claim status
- ❑ Preapproval reviews
- ❑ Covered services
- ❑ PLUS providers, including preferred vendors and specialized health facilities
- ❑ Plan benefits
- ❑ Resources on the unicarestateplan.com website

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

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

Using the unicarestateplan.com website

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

The 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
- ❑ PLUS providers in other states
- ❑ Preferred vendors
- ❑ Specialized health facilities
- ❑ Urgent care centers
- ❑ Retail health clinics

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

Compare costs and earn cash rewards at Massachusetts facilities

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

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

Using SmartShopper does not change your plan benefits or your member costs (copays, deductible and coinsurance). Be sure to select a Tier 1 or Tier 2 facility 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 Customer Service at 800-442-9300
- ❑ **Email** UniCare Customer Service at contact.us@anthem.com
- ❑ **Mail** your written request to:

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

How to check on your claims

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

- ❑ Call 800-442-9300 and select the option to access our automated information line.
- ❑ 💻 Go to unicarestateplan.com and set up a user account (page 114).

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 Customer Service at 800-442-9300 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.

8: Plan Definitions

Adverse benefit determination (Appendix E) – A determination to deny, reduce or terminate, or fail to provide or make a payment (in whole or in part) for a benefit based on any of the following:

- ❑ The case does not meet the Plan's requirements for medical necessity, appropriateness, 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 (page 27) – The maximum amount on which payment is based for covered health care services. If a non-Massachusetts provider charges more than the allowed amount, you may have to pay the difference. (Also see "balance billing.")

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

Appeal (Appendix E) – A request that UniCare review an adverse benefit determination or a grievance.

Balance billing (pages 28-29) – When a provider bills you for the difference between the provider's charge and the amount paid by the Plan (the allowed amount). For example, if the provider's charge is $100 and the allowed amount is $70, the provider may balance bill you for the remaining $30. Under Massachusetts General Law, Chapter 32A: Section 20, Massachusetts providers are prohibited from balance billing you.

Behavioral health services (pages 141-168) – Mental health, substance use disorder and Enrollee Assistance Program (EAP) services. The benefits for these services are administered by Beacon Health Options and are described in Part 3 of this handbook.

Coinsurance (page 26) – 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 deductibles that may apply.

Copay/copayment (pages 23-26) – A fixed amount (for example, $20) you pay for a covered health care service, usually when you get the service. The dollar amount of the copay depends on the service it applies to. Not all services have copays.

Cosmetic services (page 78) – Services performed mainly to improve appearance. These services do not restore bodily function or correct functional impairment. Cosmetic services are not covered.

Custodial care (page 78) – 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.

Deductible (pages 21-22) – A set amount you must pay toward covered health care services before the Plan starts to pay. For example, if your deductible is $500, the Plan won't pay anything until you've paid that amount toward services that are subject to the deductible. Deductibles don't apply to all services. There are two separate medical deductibles: the PLUS deductible, which applies to PLUS providers, and the non-PLUS deductible, which applies to non-PLUS providers and out-of-network behavioral health providers.

Dependent (Chapter 6)

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

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

Elective – A medical service or procedure is elective if you can schedule it in advance, choose where to have it done, or both.

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

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

Grievance – A complaint that you communicate to the Plan.

Hospital/acute care hospital (pages 55-57) – 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

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

Long-term care facilities (pages 55-57) – 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.

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

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

Non-preferred vendor (page 29) – 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 is 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 limit (page 26) – 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 limit, the Plan starts to pay 100% of the allowed amount. There are three separate out-of-pocket limits, each of which applies to different services:

- ❑ Out-of-pocket limit for services from PLUS providers and in-network behavioral health providers
- ❑ Out-of-pocket limit for services from non-PLUS providers and out-of-network behavioral health providers
- ❑ Out-of-pocket limit for prescription drugs

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

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

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

PLUS provider – PLUS providers are all physicians and hospitals in Massachusetts. PLUS providers also include preferred vendors, non-Massachusetts providers in the UniCare network, contracted retail and urgent care clinics, and contracted specialized health facilities.

Preapproval (pages 15-19) – 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 (page 29) – Providers that the Plan contracts with to provide certain services or equipment including, but not limited to, durable medical equipment (DME), medical supplies, and home health care. You receive these services at a higher benefit level when you use preferred vendors.

Rehabilitation facilities (pages 55-57) – 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 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 (page 90) – Walk-in clinics located in retail stores or pharmacies. They offer basic services like vaccinations and treatment for colds or mild sinus infections. CVS's MinuteClinic is a retail health clinic.

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

Skilled nursing facility (pages 55-57) – 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.

Tiers (page 93) – Different levels that the Plan groups specialists and hospitals into, based upon an evaluation of certain quality and cost-efficiency measures.

Urgent care center (page 90) – 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.

8: Plan Definitions

PART 2:
YOUR PRESCRIPTION DRUG PLAN

Description of Benefits

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

Administered by

CVS CAREMARK

Part 2: Prescription Drug Plan

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

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

About Your Plan

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

The plan categorizes medications into seven major categories:

Generic Drugs

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

Maintenance Drug

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

Non-Preferred Brand-Name Drug

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

Preferred Brand-Name Drug

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

Preventive Drugs

Preventive drugs consist primarily of drugs recommended for coverage by the U.S. Preventive Services Task Force, and as specified by the federal Patient Protection and Affordable Care Act. See preventive drugs on page 130 for more information.

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

Specialty Drugs

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

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

Over-the-Counter (OTC) Drugs

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

Copayments 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 12. 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 13. Copayments for Prescription Drugs

Copayment for	Participating Retail Pharmacy up to 30-day supply	Mail Service or CVS Pharmacy up to 90-day supply
Tier 1 – Generic Drugs	$10	$25
Tier 2 – Preferred Brand-Name Drugs	$30	$75
Tier 3 – Non-Preferred Brand-Name Drugs	$65	$165
Other ▪ Orally-administered anti-cancer drugs ▪ 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

Table 13. Copayments for Prescription Drugs *(continued)*

Copayment for	Specialty Drugs – One 30-day prescription allowed at any participating pharmacy; thereafter must be filled only through CVS Caremark Specialty Pharmacy
Specialty Drugs: Tier 1	$10 up to a 30-day supply
Specialty Drugs: Tier 2	$30 up to a 30-day supply
Specialty Drugs: Tier 3	$65 up to a 30-day supply
Orally-administered anti-cancer specialty drugs	$0 up to a 30-day supply

Out-of-Pocket Limit

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

Table 14. Out-of-Pocket Limit

Individual	$1,500
Family	$3,000

How to Use the Plan

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

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

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

Filling Your Prescriptions

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

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

Short-Term Medications – Up to 30 Days

Filling Your Prescriptions at a Participating Retail Pharmacy

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

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

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

Maintenance Medications – Up to 30 Days

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

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

Maintenance Medications – Up to 90 Days

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

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

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

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

Convenient for You

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

Using Mail Service

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

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

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

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

CVS Caremark Specialty Pharmacy

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

You are allowed one fill of a specialty drug at any participating retail pharmacy. After the first fill, a specialty drug must be filled only through the CVS Caremark Specialty Pharmacy. This means that your prescriptions can be sent to your home, your doctor's office, or your local CVS Pharmacy.

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

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

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

CVS Caremark Specialty Pharmacy Services

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

Specialty Starter Fill Program

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

Claim Forms

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

Table 15. Claims Reimbursement

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

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

Other Plan Provisions

Preventive Drugs

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

Preventive Drugs	
Aspirin	Generic OTC versions when prescribed for adults age 45 or older for the prevention of heart attack or stroke. Generic OTC low-dose aspirin to help prevent illness and death from preeclampsia for females, after 12 weeks of pregnancy, who are at high risk for the condition.
Bowel preparation medications	Generic and brand prescription products for adults ages 50 to 74 years
Contraceptives	Generic and brand versions of contraceptive drugs and devices, and OTC contraceptive products, when prescribed for women
Folic acid supplements	Generic OTC versions when prescribed for women under the age of 56 planning or capable of pregnancy
Immunization vaccines	Generic or brand versions prescribed for children or adults. (Coverage for prescription drug vaccines only. No coverage of charges by pharmacies for the administration of vaccines.)
Oral fluoride supplements	Generic and brand supplements prescribed for children five years of age or under for the prevention of dental caries
Breast cancer	Generic prescriptions for raloxifene or tamoxifen are covered for the primary prevention of breast cancer for females who are at increased risk, age 35 years and older
Tobacco cessation	Generic, brand and OTC products prescribed for adults for the purpose of smoking cessation
Vitamin D supplements	Single ingredient OTC products prescribed for adults age 65 years and older

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

Brand-Name Drugs with Exact Generic Equivalents

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

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

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

Please note: Generic drugs used to treat opioid use disorder (generic buprenorphine-naloxone, naloxone, and naltrexone products) do not require prior authorization.

Table 16. Current Examples of Drugs Requiring Prior Authorization for Specific Conditions[1]

Drug Class	Products Requiring Prior Authorization (PA)
Acne	Tazorac/Fabior
	Topical Retinoids (Atralin, Avita, Retin-A, Retin-A Micro, Tretin-X, tretinoin, Veltin, Ziana) – *PA required only in adults age 36 and older*
Anabolic Steroids	Anadrol-50, Oxandrin
Antifungals, Topical	Ciclopirox Products, Lamisil, Itraconazole products
Compounded Medications*	Select medications * *A compounded medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available.*
Diabetes	Fortamet (and the generic equivalent metformin ER)
Gastrointestinal	Omeprazole-bicarbonate
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)
	Butrans
Testosterone Products	Injectable, Oral, Topical/Buccal/Nasal products (AndroGel, Androderm, Axiron, Delatestryl, Depo-Testosterone, Fortesta, methyltestosterone, Natesto, Striant, Testim, Testosterone Cream, Testosterone Ointment, Testosterone Powder, Vogelxo Topical Gel)
Weight Management	Adipex-P, Belviq, Benzphetamine, Bontril SR, Bontril PDM, Contrave, Didrex, Diethylpropion, Phendimetrazine/ER/SR, Phentermine, Qsymia, Regimex, Saxenda, Suprenza, Xenical
Miscellaneous	Regranex

Table 17. Current Examples of Top Drug Classes that May Require Prior Authorization for Medical Necessity[1]

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

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

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

Quantity Dispensing Limits

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

Quantity per dispensing limits are based on the following:

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

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

Drug Utilization Review Program

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

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

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

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

Exclusions

Benefits exclude:[1]

- Dental preparations (e.g. topical fluoride, Arestin), with the exception of oral fluoride
- Preventive Drugs for children six years of age or under
- Over-the-counter drugs, vitamins or minerals (with the exception of diabetic supplies and Preventive Drugs)
- 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 or food products, except as required by state law
- 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.

1 This list is subject to change during the year.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Member Appeals

CVS Caremark has processes to address:

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

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

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

All calls should be directed to Customer Care at 877-876-7214.

Internal Inquiry

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

Internal Member Appeals

Requests for coverage that were denied as specifically excluded in this member handbook or for coverage that was denied based on medical necessity determinations are reviewed as appeals through CVS Caremark's Internal Appeals Process. You may file an appeal request yourself or you may designate someone to act on your behalf in writing. You have 180 days from the date you were notified of the denial of benefit coverage or prescription drug claim payment to file your appeal.

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

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

A copy of the decision letter will be sent to you and your physician. A determination of denial will set forth:

- ❑ CVS Caremark's understanding of the request;
- ❑ The reason(s) for the denial;
- ❑ Reference to the contract provisions on which the denial is based; and
- ❑ A clinical rationale for the denial, if the appeal involves a medical necessity determination.

CVS Caremark maintains records of each inquiry made by a member or by that member's designated representative.

Expedited Appeals

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

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

External Review Appeals

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

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

In some cases, members may have the right to an expedited external review. An expedited external review may be appropriate in urgent situations. Generally, an urgent situation is one in which your health may be in serious jeopardy, or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal.

If you request an external review, an independent organization will review the decision and provide you with a written determination. If this organization decides to overturn the Appeals decision, the service or supply will be covered under the plan.

If you have questions or need help submitting an appeal, please call Customer Care for assistance at 877-876-7214.

Health and Prescription Information

Health and prescription information about members is used by CVS Caremark to administer benefits. As part of the administration, CVS Caremark may report health and prescription information to the administrator or sponsor of the benefit plan. CVS Caremark also uses that information and prescription data gathered from claims nationwide for reporting and analysis without identifying individual members.

PART 3:

YOUR BEHAVIORAL HEALTH PLAN

Description of Benefits for Mental Health, Substance Use Disorder and the Enrollee Assistance Program

For questions about any of the information in Part 3 of this handbook, please contact Beacon Health Options at 855-750-8980.

Administered by

beacon health options

Part I – How to Use this Plan

As a member of this plan, you are automatically enrolled in the mental health/substance use disorder benefits program and the Enrollee Assistance Program (EAP) administered by Beacon Health Options (Beacon). Beacon offers easy access to a wide variety of services, including assistance with day-to-day concerns and acute mental health and substance use disorder treatment. Beacon's comprehensive coverage ranges from traditional and intensive outpatient services to acute residential programs to acute inpatient care.

Beacon's member-driven and provider-centric approach seeks to improve your well-being and functioning as quickly as possible. Our primary goal is to offer you and your family "the right care, in the right setting, for the right amount of time" through our network of high quality, skilled providers.

How to Contact Beacon Health Options

Phone	**855-750-8980**	**TTY: 711**
Website	beaconhealthoptions.com/gic	The website offers wellness articles, a Beacon provider directory, benefits information, and other helpful tools.
Hours of Operations	**For specific benefits or claims questions:** Call a customer service representative Monday through Friday from 8 a.m. to 7 p.m., Eastern Time (ET). **For clinical support:** A qualified Beacon clinician will answer your call 24 hours a day, seven days a week, to verify your coverage and refer you to a specialized EAP resource or an in-network provider.	

How to Get Optimal Benefits

Taking two important steps will help you receive the highest level of benefits and lower your out-of-pocket expenses:

Step 1: Use a provider or facility that is part of the Beacon Health Options network.

Step 2: Call Beacon Health Options to obtain a referral for EAP services, or to obtain prior authorization for non-routine outpatient and inpatient care. For a list of non-routine services, see "Definitions of Beacon Health Options Behavioral Health Terms."

In-network providers – Beacon has a comprehensive network of experienced providers, all of whom have met our rigorous credentialing process. These in-network providers – including providers in physical settings and telehealth providers – offer you the highest level of quality care for mental health, substance use disorder, and EAP services.

Out-of-network providers – Your benefits will be lower if you receive care from a provider or facility that is not part of Beacon's network. These reduced benefits are called out-of-network benefits.

Note: Benefits will be denied if your care is not considered a covered service.

We encourage you to call Beacon at 855-750-8980 (TTY: 711) before using your mental health, substance use disorder, or EAP benefits. A qualified Beacon clinician will answer your call 24 hours a day, seven days a week, to assist you with both routine and urgent matters. Our clinicians can verify your coverage and refer you to an in-network provider who matches your specific request (e.g., provider location, gender, or fluency in a second language). Beacon clinicians can also provide you with a referral for brief counseling, or legal, financial, or dependent care assistance through your EAP.

Customer service representatives are also available from 8 a.m. to 7 p.m. ET to help you with specific benefits or claims questions.[1]

Referral/Prior Authorization for EAP and Non-Routine Services

You must obtain prior authorization for non-routine outpatient services and inpatient care requests. You must also obtain a referral from Beacon for EAP services. Beacon clinicians are available 24 hours a day, seven days a week at **855-750-8980** (**TTY: 711**) to provide referrals and prior authorization.

After you obtain prior authorization, you can then call the provider of your choice directly to schedule an appointment. Beacon maintains an extensive database at **beaconhealthoptions.com/gic** where you can search for in-network providers.

If you (or your provider) do not call Beacon to obtain prior authorization or a referral, your benefits may be reduced or not paid at all.

Emergency Care

You should seek emergency care if you (or your covered dependents) need immediate clinical attention because you present a significant risk to yourself or others.

In a life-threatening emergency, you should seek care immediately at the closest emergency facility.

Beacon will not deny emergency care. However, ***you, a family member, or your provider must notify Beacon within 24 hours of an emergency admission.***

Although a representative may call on your behalf, it is always your responsibility to make certain that Beacon has been notified of an emergency admission. Your benefits may be reduced or denied if you do not notify Beacon.

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

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

Urgent Care

You should seek urgent care if you have a condition that may become an emergency if it is not treated quickly. In such situations, our providers will have appointments to see you within 48 hours of your initial call to Beacon. Contact Beacon if you need assistance finding an in-network provider with urgent care appointment availability.

Routine Care

Routine care is appropriate if you have a condition that presents no serious risk and is not likely to become an emergency. In-network providers will have appointments to see you within ten days of your initial call to Beacon for routine care. Contact Beacon if you need assistance finding an in-network provider with appointment availability.

Confidentiality

When you use your EAP, mental health, and substance use disorder benefits under this plan, you consent to release necessary clinical records to Beacon for case management and benefit administration. This information is provided only to the extent necessary to administer and manage the care provided when you use your benefits, and in accordance with state and federal laws. All of your records, correspondence, claims and conversations with Beacon staff are kept **completely confidential** in accordance with state and federal laws. No information may be released to your supervisor, employer or family without your written permission. No one will be notified when you use your EAP, mental health and substance use disorder benefits. However, if you inform Beacon that you are seriously considering harming yourself or others, Beacon is legally required to notify emergency services to ensure your safety, even without your permission.

Coordination of Benefits

You and your dependents may be entitled to receive benefits from more than one plan. When this occurs, your plans use coordination of benefits (COB) to determine coverage for your mental health and substance use disorder benefits. All benefits under this plan are subject to COB. Beacon may request information from you about other health insurance coverage in order to process your claims.

Part II – Benefits

Benefits Explained

Your Member Costs

Deductible – A deductible is the amount you must pay each plan year before Beacon starts to pay your out-of-network mental health and substance use disorder (behavioral health) benefits. (In-network behavioral health services are not subject to the deductible.) You have an out-of-network deductible of $500 for one person or $1,000 for the entire family for out-of-network mental health and substance use disorder treatment. The most you'll owe for any one family member is $500, until the family as a whole reaches the $1,000 deductible limit. This deductible is shared between out-of-network medical services (that is, services from non-PLUS providers) and out-of-network behavioral health services.

Copayments (copays) – Copays are a set amount you pay when you get certain mental health or substance use disorder services. You have two different types of copays for behavioral health services under this plan:

- **Per-visit copays** – These are copays you pay every time you have a particular service. Outpatient visits all have per-visit copays.
- **Quarterly copays** – You pay quarterly copays only once per quarter, no matter how many times you get that service during the quarter. There are quarterly copays for inpatient and intermediate mental health and substance use disorder care. (The quarters are: July/August/September, October/November/December, January/February/March, and April/May/June.)

Out-of-Pocket Limit – The out-of-pocket limit is the maximum amount you will pay in deductibles, copays, and coinsurance (if applicable) for your medical, mental health and substance use disorder care in one plan year. When you have met your out-of-pocket limit, all care will be covered at 100% of the allowed amount until the end of the year.

You have two separate out-of-pocket limits: an **out-of-pocket limit for in-network services, and an out-of-pocket limit for out-of-network services**. Neither limit includes the following:

- Charges for out-of-network care that exceeds the maximum number of days or visits
- Charges for care that is not a covered service
- Charges in excess of Beacon's allowed amounts

In-Network Benefits

Covered **in-network** services are paid at 100%, after copays (see copay schedule in Table 18, below). If you receive multiple outpatient behavioral health services on the same day, from the same provider, you will only pay one copay. (The higher copay will apply).

In-network behavioral health services are not subject to the **deductible**.

The **out-of-pocket limit for in-network services** is $4,000 for one person or $8,000 for the entire family, shared with your in-network medical expenses. Only copays for covered in-network services apply to this limit. The cost of treatment that is subject to exclusions does not count toward the out-of-pocket limit. Once you reach your in-network out-of-pocket limit in a plan year, all covered in-network services you receive are covered at 100% until the end of that plan year.

Out-of-Network Benefits

Out-of-network benefits are paid at a lower level than in-network benefits and are subject to deductibles and copays. Out-of-network benefits are paid based on allowed amounts, which are Beacon's "reasonable and customary" fees, a percentage of Medicare, or negotiated fee maximums. Allowed amounts are subject to change at any time without notice. If your out-of-network provider or facility charges more than these allowed amounts, **you may be balance billed** (asked to pay for charges above the allowed amount). Beacon does not cover balance bills.

> Beacon's in-network providers must accept the Plan's allowed amounts, so you won't be balance billed as long as you use providers in the Beacon network. Call Beacon at 855-750-8980 (TTY: 711) for help finding an in-network provider.

You have a **deductible** of $500 for one person or $1,000 for the entire family for out-of-network mental health and substance use disorder treatment. This is shared with your out-of-network (non-PLUS) medical expenses.

The **out-of-pocket limit for out-of-network services** is $5,000 for one person or $10,000 for the entire family, shared with your out-of-network (non-PLUS) medical expenses. The out-of-network out-of-pocket limit applies to the deductible and copays for covered out-of-network behavioral health services and non-PLUS medical expenses. Once you reach your out-of-network out-of-pocket limit in a plan year, all covered out-of-network services you receive are covered at 100% of the allowed amount until the end of that plan year.

> **Important!** Once you have met your annual out-of-pocket limit, you continue to pay for any costs in excess of allowed amounts.

You cannot use the following to satisfy your out-of-pocket limit:

- ❑ Charges for out-of-network care that exceeds the maximum number of days or visits
- ❑ Charges for care that is not a covered service
- ❑ Charges in excess of Beacon's allowed amounts

Table 18 outlines your costs for mental health, substance use disorder and EAP services.

Table 18. Mental Health, Substance Use Disorder, and EAP Benefits

Covered Services	In-Network Benefits	Out-of-Network Benefits
Deductible *Shared with applicable medical expenses*	None	$500 for one person, or $1,000 for the entire family
Out-of-Pocket Limit *Shared with applicable medical expenses*	$4,000 for one person, or $8,000 for the entire family	$5,000 for one person, or $10,000 for the entire family
Inpatient Care[1]		
Mental Health General hospital or psychiatric hospital	$200 inpatient care copay per calendar quarter[2]	$200 inpatient care copay per calendar quarter,[2] then 80% coverage of the allowed amount Subject to deductible
Substance Use Disorder General hospital or substance use disorder facility	$200 inpatient care copay per calendar quarter[2]	$200 inpatient care copay per calendar quarter,[2] then 80% coverage of the allowed amount Subject to deductible
Intermediate Care Including, but not limited to, crisis stabilization, acute residential treatment (Level 3.5), day/partial hospitals, structured outpatient treatment programs	$200 inpatient care copay per calendar quarter[2]	$200 inpatient care copay per calendar quarter,[2] then 80% coverage of the allowed amount Subject to deductible
Outpatient Care – Mental Health, Substance Use Disorder and Enrollee Assistance Program		
Individual and Family Therapy[3]	$20 copay	$30 copay, then 100% coverage of the allowed amount Subject to deductible
Specialty Outpatient Services Autism Spectrum Disorder services, ECT, TMS, psychiatric VNA, neuropsychological / psychological testing, acupuncture detox, and DBT	$20 copay	$30 copay, then 100% coverage of the allowed amount Subject to deductible
Group Therapy, all types Includes Autism Spectrum Disorder group therapy visits	$15 copay	$30 copay, then 100% coverage of the allowed amount Subject to deductible

1 You must obtain prior authorization for most inpatient, intermediate and hospital care. Please see Table 19, "Summary of Covered Services," or call Beacon at 855-750-8980 for details. You must notify Beacon within 24 hours of emergency admissions to receive maximum benefits.

2 Waived if readmitted within 30 days, with a maximum of one inpatient/intermediate care copay per calendar quarter.

3 You receive up to 26 medically necessary individual/family therapy visits per member, per plan year without prior authorization. Prior authorization is required for individual/family visits (including therapy done in conjunction with medical management) beyond 26 per benefit year.

Table 18. Mental Health, Substance Use Disorder, and EAP Benefits *(continued)*

Covered Services	In-Network Benefits	Out-of-Network Benefits
Outpatient Care – Mental Health, Substance Use Disorder and Enrollee Assistance Program *(continued)*		
Medication Management	$15 copay	$30 copay, then 100% coverage of the allowed amount Subject to deductible
Telehealth Services (online video-based counseling or medication management provided by American Well)[1]	$15 copay	No coverage
Urine Drug Screening In conjunction with in-network substance use disorder treatment	No copay	N/A (out-of-network lab and urine tests are covered by UniCare; please see Part 1 of this handbook for details)
Provider Eligibility: Providers must be independently licensed in their specialty area or working under the supervision of an independently licensed clinician in a facility or licensed clinic. Examples include: MD psychiatrist, PhD, PsyD, EdD, LICSW, LMHC, LMFT, RNCS, BCBA.		
Enrollee Assistance Program (EAP) Including, but not limited to, depression, marital issues, family problems, alcohol and drug use, and grief. Also includes referral services – legal, financial, child and elder care **Note:** All EAP services require you to obtain a referral from Beacon. Failure to do so results in loss of coverage.	**Counseling:** Up to 3 visits per member per year, with no copay **Legal:** 30-minute consultation with a local independent attorney and 25% off the hourly rate for services beyond the initial consultation **Financial:** ▪ 30-minute phone consultation with a financial counselor for assistance with issues such as credit repair, debt management, and budgeting. ▪ 30-minute phone consultation with a local, independent financial planner, and 15% off his/her standard rate for preparing a financial plan. **Child and elder care:** access to referrals in your area **Domestic violence resources:** access to a confidential hotline and supportive services	No coverage

1 You receive up to 26 medically necessary individual/family therapy visits per member, per plan year without prior authorization. Prior authorization is required for individual/family visits (including therapy done in conjunction with medical management) beyond 26 per benefit year.

What This Plan Pays: Summary of Covered Services

The Plan pays for the services listed in Table 19. All services must meet medical necessity criteria to be covered.

Table 19. Summary of Covered Services[1]

Service	Applicable Copay type (see grid above for copay amounts)	Prior Authorization Required?
Acupuncture Withdrawal Management	Individual/Family Therapy	**In-Network:** No **Out-of-Network, MA DPH Licensed Provider:** Notification of admission required within 48 hours **Out-of-Network, Non-MA DPH Licensed Provider:** Prior authorization required
Acute Inpatient Psychiatric Services	Inpatient Care	Yes
Acute Residential Treatment	Intermediate Care	Yes
Adolescent Acute Inpatient Withdrawal Management and Rehabilitation for Substance Use Disorder (Level 3.5)	Inpatient Care	**In-Network, or Out-of-Network, MA DPH Licensed Provider:** Notification of admission required within 48 hours **Out-of-Network, Non-MA DPH Licensed Provider:** Prior authorization required
Adult Crisis Stabilization Unit (CSU)	Intermediate Care	Yes
Ambulatory Withdrawal Management	Medication Management	No
Applied Behavior Analysis (ABA)	Individual/Family Therapy	Yes
Clinical Stabilization Services (CSS) for Substance Use Disorder (Level 3.5)	Intermediate Care	**In-Network, or Out-of-Network, MA DPH Licensed Provider:** Notification of admission required within 48 hours **Out-of-Network, Non-MA DPH Licensed Provider:** Prior authorization required
Community Based Acute Treatment (CBAT)	Intermediate Care	Yes

1 These services are subject to certain exclusions, which can be found in "What's Not Covered – Exclusions" (page 158). Failure to obtain prior authorization, when required, may result in no coverage.

Table 19. Summary of Covered Services *(continued)*[1]

Service	Applicable Copay type (see grid above for copay amounts)	Prior Authorization Required?
Community Support Programs (CSP)	Intermediate Care	Yes
Day Treatment	Intermediate Care	Yes
Dialectical Behavioral Therapy (DBT)	Individual/Family Therapy	Yes
Drug Screening (urine) *In conjunction with substance use disorder treatment*	No copay (covered in-network only)	No
Dual Diagnosis Acute Treatment (DDAT) (Level 3.5)	Intermediate Care	**In-Network, or Out-of-Network, MA DPH Licensed Provider:** Notification of admission required within 48 hours **Out-of-Network, Non-MA DPH Licensed Provider:** Prior authorization required
Electroconvulsive Therapy (ECT)	Individual/Family Therapy	Yes
Emergency Service Programs (ESP)	No copay	No
Enrollee Assistance Program (EAP)	No copay	Yes (referral)
Family Stabilization Team (FST)	Intermediate Care	Yes
Group Therapy	Group Therapy	No
Individual/Family Therapy (conducted in the provider's office/facility, or, if appropriate, in a member's home)	Individual/Family Therapy	Prior authorization is required for more than 26 visits per plan year
Inpatient Substance Use Disorder Services – Medically Managed (Level 4 detox)	Inpatient Care	**In-Network, or Out-of-Network, MA DPH Licensed Provider:** Notification of admission required within 48 hours **Out-of-Network, Non-MA DPH Licensed Provider:** Prior authorization required

1 These services are subject to certain exclusions, which can be found in "What's Not Covered – Exclusions" (page 158). Failure to obtain prior authorization, when required, may result in no coverage.

Table 19. Summary of Covered Services *(continued)*[1]

Service	Applicable Copay type (see grid above for copay amounts)	Prior Authorization Required?
Intensive Outpatient Programs (IOP) for Mental Health	Intermediate Care	**In-Network:** No, for first 6 units within 14 days. Authorization required for subsequent units. **Out-of-Network:** Prior authorization required
Intensive Outpatient Programs (IOP) for Substance Use Disorder (Level 2.1)	Intermediate Care	**In-Network:** No, for first 6 units within 14 days. Authorization required for subsequent units. **Out-of-Network, MA DPH Licensed Provider:** Notification of admission required within 48 hours **Out-of-Network, Non-MA DPH Licensed Provider:** Prior authorization required
Medication Management	Medication Management	No
Methadone Maintenance	No copay	No
Observation	Inpatient Care	No
Partial Hospitalization Programs (PHP) for Mental Health	Intermediate Care	Yes
Partial Hospitalization Programs (PHP) for Substance Use Disorder (Level 2.5)	Intermediate Care	**MA DPH Licensed Provider:** Notification of admission required within 48 hours **Out-of-Network, Non-MA DPH Licensed Provider:** Prior authorization required
Psychiatric Visiting Nurse services	Individual/Family Therapy	Yes
Psychological and Neuropsychological Testing	Individual/Family Therapy	Yes
Residential Withdrawal Management (Acute) – Medically Monitored/Acute Treatment Services (Level 3.7 Detox)	Intermediate Care	**In-Network, or Out-of-Network, MA DPH Licensed Provider:** Notification of admission required within 48 hours **Out-of-Network, Non-MA DPH Licensed Provider:** Prior authorization required

1 These services are subject to certain exclusions, which can be found in "What's Not Covered – Exclusions" (page 158). Failure to obtain prior authorization, when required, may result in no coverage.

Table 19. Summary of Covered Services *(continued)*[1]

Service	Applicable Copay type (see grid above for copay amounts)	Prior Authorization Required?
Structured Outpatient Addictions Programs (SOAP)	Intermediate Care	**In-Network:** No authorization required for initial 20 units in 45 days per member. Authorization required for subsequent units. **Out-of-Network, MA DPH Licensed Provider:** Notification of admission required within 48 hours **Out-of-Network, Non-MA DPH Licensed Provider:** Prior authorization required
Substance Use Disorder Assessment and Referral	No copay	No
Telehealth services (online video-based counseling or medication management from American Well or Beacon telehealth providers)	Telehealth services	**Therapy:** Prior authorization is required for more than 26 visits per plan year **Medication Management:** No authorization required Please call Beacon for referrals.
Transcranial Magnetic Stimulation (TMS)	Individual/Family Therapy	Yes
Transitional Care Unit (TCU) – (for children in custody of Department of Children & Families)	Intermediate Care	Yes

All services must be deemed covered services and all charges are subject to the Plan's allowed amount for that service.

1 These services are subject to certain exclusions, which can be found in "What's Not Covered – Exclusions" (page 158). Failure to obtain prior authorization, when required, may result in no coverage.

Covered Services

Routine Outpatient Services

Routine Services – Routine outpatient services (listed below) do not require prior authorization.

- ❑ Outpatient therapy (individual/family therapy, including therapy done in conjunction with medication management), up to 26 visits per member, per year
- ❑ Group therapy that is 45 to 50 minutes in duration
- ❑ Medication management, either in person or via telehealth
- ❑ Methadone maintenance
- ❑ In-network urine drug screening as a medically necessary part of substance use disorder treatment
- ❑ Emergency service programs (ESP)
- ❑ Telehealth services (online video-based counseling) up to 26 visits per member, per year

Outpatient therapy (including telehealth counseling) visits beyond 26 per plan year are defined as non-routine and require prior authorization.

Routine out-of-network outpatient care is paid at 100% of the allowed amount, after a $30 copay per visit. Out-of-network outpatient care is subject to the deductible.

If you receive multiple outpatient behavioral health services on the same day, from the same provider, you will be charged one copay. (The higher copay will apply.)

Non-Routine (Specialty) Outpatient Services

Non-Routine (Specialty) Outpatient Services – ***You must obtain prior authorization for most non-routine outpatient care.*** Please see Table 19, "Summary of Covered Services," for details on authorization requirements. Failure to obtain prior authorization for non-routine outpatient care may result in no coverage.

> Please see "Definitions of Beacon Health Options Behavioral Health Terms" (page 162) for a full listing of non-routine services.

If you receive multiple outpatient behavioral health services on the same day, from the same provider, you will be charged one copay. (The higher copay will apply.)

Autism Spectrum Disorders – The plan will cover medically necessary services provided for the diagnosis and treatment of autism spectrum disorders. Coverage is pursuant to the requirements of the plan and to Massachusetts law, including, without limitation:

- ❑ Professional services, including care by appropriately credentialed, licensed or certified psychiatrists, psychologists, social workers, and board-certified behavior analysts.
- ❑ Habilitative / rehabilitative care, including, but not limited to, Applied Behavior Analysis (ABA) by a board-certified behavior analyst as defined by law.

Beacon's specialized autism case managers can provide any necessary prior authorization and help you locate an in-network provider. Please call Beacon at 855-750-8980 to speak to an **autism case manager**.

- ❑ **Applied Behavior Analysis Services (ABA)** – Coverage for ABA-related services is based on medical necessity criteria. ***You must obtain prior authorization for all ABA services.*** Failure to obtain prior authorization may result in no coverage. Covered services include:
  - Skills assessment by a Board Certified Behavioral Analyst (BCBA) or qualified licensed clinician
  - Conjoint supervision of paraprofessionals by a BCBA or qualified licensed clinician, with clients present
  - Treatment planning conducted by a BCBA or qualified licensed clinician
  - Direct ABA services by a BCBA, licensed clinician, or paraprofessional (if appropriately supervised)
- ❑ **Psychiatric Services** – Psychiatric services for autism spectrum disorders are focused on treating maladaptive/stereotypic behaviors that pose a danger to self, others and/or property, and impair daily functioning. Covered services include:
  - Diagnostic evaluations and assessment
  - Treatment planning
  - Referral services
  - Medication management
  - Inpatient/24-hour supervisory care ***(prior authorization required)***
  - Partial Hospitalization/Day Treatment ***(prior authorization required)***
  - Intensive Outpatient Treatment ***(prior authorization required)***
  - Services at an Acute Residential Treatment Facility ***(prior authorization required)***
  - Individual, family, therapeutic group, and provider-based case management services
  - Psychotherapy, consultation, and training session for parents and paraprofessional and resource support to family
  - Crisis Intervention
  - Transitional Care ***(prior authorization required)***

Psychological/Neuropsychological Testing

You must obtain prior authorization for psychological testing. Failure to obtain prior authorization for psychological testing may result in no coverage.

You must obtain prior authorization for neuropsychological testing for mental health conditions. Failure to obtain prior authorization for neuropsychological testing may result in no coverage.

> **Note:** Neuropsychological testing for medical conditions is covered under the medical component of your plan.

Urine Drug Screening

In-network urine drug screening is covered when it is a medically necessary part of substance use disorder treatment. (Screening that is conducted as part of methadone treatment is billed as part of the methadone services.)

Urine drug screening must be done by certified in-network providers. Beacon does not provide coverage for out-of-network providers or laboratories, or for uncertified in-network providers.

> **Note:** Urine drug screens completed by laboratories or out-of-network providers *may* be covered by the medical component of your plan. Contact UniCare at 800-442-9300 for information about coverage under the medical component of your plan.

Intermediate Care

In-network intermediate care in a general or psychiatric hospital or a substance use disorder facility is covered at 100%, after a $200 copay per calendar quarter. The copay is waived if you are readmitted within 30 days of discharge.

Out-of-network intermediate care is paid at 80% of the allowed amount, after a $200 copay per calendar quarter. Out-of-network intermediate care is subject to the deductible.

You or your provider must obtain prior authorization for intermediate care. Failure to obtain prior authorization may result in no coverage.

Inpatient Care

In-network inpatient care in a general or psychiatric hospital or a substance use disorder facility is covered at 100%, after a $200 copay per calendar quarter. The copay is waived if you are readmitted within 30 days of discharge.

Out-of-network inpatient care in a general or psychiatric hospital or a substance use disorder facility is paid at 80% of the allowed amount, after a $200 copay per calendar quarter. Out-of-network inpatient care is subject to the deductible. If you are admitted to an out-of-network inpatient facility through an emergency room, and there are no in-network providers available, you will only be responsible for your in-network copay. Beacon will reimburse the facility the out-of-network allowed amount for the service. Please check with the facility to determine if you will be subject to balance billing.

If you require psychiatry visits/consultations while receiving inpatient care, these visits will be covered at 100%.

You or your provider must obtain prior authorization for inpatient care. Failure to obtain prior authorization may result in no coverage.

Telehealth Services

Beacon is committed to providing access to quality behavioral health care when and where you need it. Beacon has enhanced our network by adding online video-based counseling services (telehealth), through American Well.

Telehealth services through American Well (AmWell) allows you to easily access a range of behavioral health services, including assessments, counseling, and medication management, from the comfort of your home. Telehealth is immediate, secure, and confidential. It is also easy to use – all you need is a smartphone, tablet or computer with Internet access and a camera.

To schedule a live session with a Beacon AmWell telehealth provider, call Beacon's Member Services at 855-750-8980. A member services representative can either schedule your appointment or register you with American Well so you can choose a provider and schedule an appointment yourself. You can also directly register and search for a provider at amwell.com. All telehealth services received through AmWell are considered in-network, and will apply a $10 copay.

Beacon also offers telehealth services through your local in-network behavioral health providers. If you're interested in locating a local behavioral health provider that offers telehealth services, please contact Beacon Member Services at 855-750-8980 or log on to beaconhealthoptions.com/gic. All telehealth services are subject to a $10 in-network copay.

The following requirements apply to telehealth services:

- ❑ The provider you use must be licensed in the state in which you receive the services.
- ❑ There is no coverage for out-of-network telehealth services.
- ❑ For in-network telehealth services not received through American Well, in-network providers are required to sign Beacon's telehealth attestation form prior to claims approval.

Enrollee Assistance Program (EAP)

The Enrollee Assistance Program (EAP) is an in-network only benefit.

Beacon's EAP can help with the following types of problems:

1. Breakup of a relationship
2. Divorce or separation
3. Becoming a stepparent
4. Helping children adjust to new family members
5. Death of a friend or family member
6. Communication problems
7. Conflicts in relationships at work
8. Legal difficulties
9. Financial difficulties
10. Child care or elder care needs
11. Aging
12. Traumatic events

Call 855-750-8980 (TTY: 711) to use your EAP benefit. A Beacon clinician will refer you to a trained EAP provider and/or other specialized resource (e.g., attorney or dependent care service) in your community. The Beacon clinician may recommend mental health and substance use disorder services if the problem seems to require help that is more extensive than EAP services can provide.

You must call to receive a referral from Beacon for all EAP services. Failure to obtain a referral may result in no coverage.

Covered services include:

- **EAP Counseling Visits** – You have access to up to three EAP counseling visits per member, per year, with an in-network licensed provider. Telehealth counseling visits provided through American Well may qualify as EAP visits. EAP counseling visits can help with problems affecting work/life balance or daily living, such as marital problems, stress at work, or difficulties adjusting to life changes. These visits are covered at 100%.
- **Legal Services** – Legal assistance services include confidential access to a local attorney to help you answer legal questions, prepare legal documents and help solve legal issues. The following free or discounted services are provided through though your legal benefit:
  - Free referral to a local attorney
  - Free 30-minute consultation (phone or in-person) per legal matter
  - 25% off the attorney's hourly rate (if the attorney charges by the hour) for services beyond the initial consultation
  - Free online legal information, including common forms and will kits
- **Financial Counseling and Planning** – Your financial counseling and planning benefit includes:
  - A 30-minute initial phone consultation with a financial counselor for assistance with issues such as credit repair, debt management, and budgeting
  - A 30-minute initial phone consultation with a local, independent financial planner, and 15% off his or her standard rate for preparing a financial plan
- **Child/Elder Care Referral Service** – Beacon's EAP can help you locate a child or elder care provider. You will receive a packet that contains informational literature, links to federal and private agencies, and a list of independent referrals in your area. There is no cost for this referral service.
- **Domestic Violence Resources and Assistance** – You have 24/7 access to a confidential, toll-free hotline that provides crisis intervention, safety planning, supportive listening, and help connecting to appropriate resources. Beacon's EAP can also provide referrals to a wide range of supportive services, including specialized counseling, temporary emergency housing, and legal assistance.
- **Employee Assistance Program for Agency Managers and Supervisors** – The Group Insurance Commission offers an Employee Assistance Program for managers and supervisors of agencies and municipalities, which offers:
  - Critical incident response services (also available to non-managers and supervisors)
  - Confidential consultations
  - Resources for dealing with employee problems such as low morale, disruptive workplace behavior, mental illness and substance use disorder
  - Team trainings on topics such as stress management and coping with challenging workplace behaviors

Case Management

Beacon's clinical case managers are available to support you and your family. Case managers will:

- ❑ Help determine the appropriate treatment for you
- ❑ Review your case using objective and evidence-based clinical criteria
- ❑ Help coordinate services among multiple providers
- ❑ Work with your providers to support your needs
- ❑ Provide available resources
- ❑ Work with your medical plan to help coordinate benefits and services
- ❑ Provide psychoeducation
- ❑ Encourage the development of a care plan to help with transitions in care

If you would like help dealing with your behavioral health situation, call Beacon at 855-750-8980 (TTY: 711) and ask to speak with a case manager.

What's Not Covered – Exclusions

This plan does not cover services, supplies or treatment relating to the below exclusions. The exclusions apply even if the services, supplies or treatment are recommended or prescribed by your provider, or if they are the only available options for your condition.

Excluded services include:

- Services performed in connection with conditions not classified in the most current edition of the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM)
- Prescription drugs or over-the-counter drugs and treatments.

  Note: These supplies may be covered under the prescription drug component of your plan.

- Services or supplies for mental health/substance use disorder treatment that, in Beacon's reasonable judgment, fits any of the following descriptions:
  - Is not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance use disorder
  - Is not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
  - Is not consistent with prevailing professional research which would demonstrate that the service or supplies will have a measurable and beneficial health outcome
  - Typically does not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; or that are consistent with Beacon's level-of-care clinical criteria, clinical practice guidelines or best practices as modified from time to time.

  Beacon may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information.

- Services, supplies or treatments that are considered unproven, investigational, or experimental because they do not meet generally accepted standards of medical practice in the United States. The fact that a service, treatment or device is the only available treatment for a particular condition will not result in it being a covered service if it is considered unproven, investigational or experimental.
- Custodial care, unless necessary for acute stabilization or to return you to your baseline level of individual functioning. Care is considered custodial when it:
  - Is primarily intended for detention in a protected, controlled environment
  - Is chiefly designed to assist in the activities of daily living, or
  - Cannot reasonably be expected to restore you to a level of functioning that would enable you to function outside a structured environment. (This applies to members for whom there is little expectation of improvement, despite any and all treatment attempts.)
  - Is provided by a Department of Mental Health (DMH) continuing care facility or other DMH-run program.
- Neuropsychological testing solely to determine a diagnosis of attention-deficit hyperactivity disorder.

  Note: Neuropsychological testing for medical conditions is covered under the medical component of your plan.

- Urine drug screening is excluded when:
  - Conducted as part of your participation in methadone treatment, which is billed as part of the methadone services
  - Completed by out-of-network providers, laboratories, or in-network providers who are not certified
- Examinations or treatment, when:
  - Required solely for purposes of career, education, housing, sports or camp, travel, employment, insurance, marriage, or adoption; or
  - Ordered by a court except as required by law; or
  - Conducted for purposes of medical research; or
  - Required to obtain or maintain a license of any type

  The above examinations or treatment may be covered if they are: (1) otherwise considered covered behavioral health services, and (2) determined by Beacon to be medically necessary.
- Herbal medicine, or holistic or homeopathic care, including herbal drugs or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
- Biofeedback
- Equestrian or pet therapy
- Expenses related to service animals

- Any service, program, supply, or procedure performed in a non-conventional setting (including, but not limited to, spas/resorts, therapeutic/residential schools, educational, vocational, or recreational settings; daycare or preschool settings; Outward Bound; or wilderness, camp or ranch programs), even if performed or provided by licensed providers (including, but not limited to, nutritionists, nurses or physicians).
- Telehealth services provided out-of-network, or via non-HIPAA compliant technology (i.e. Skype, telephone), or performed by a provider who is not licensed in the state where the member receives the service.
- The cost of the necessary technology or equipment needed to provide HIPAA-compliant telehealth services.
- Genetic testing for behavioral prescribing
- Services conducted by providers who are found to have sanctions against them
- Non-acute residential treatment, including, but not limited to, recovery residences, sober homes, Clinically Managed Low-Intensity Residential Services (Level 3.1), and Clinically Managed Population Specific High-Intensity Residential Services (Level 3.3).
- Acupuncture treatment (with the exception of acupuncture withdrawal management, which is a covered benefit)
- Multiple charges for the same service or procedure, on the same date.
- Facility charges for covered outpatient services.
- Nutritional counseling

  Note: These services are covered under the medical component of your plan.

- Professional anesthesia services related to electroconvulsive treatment (ECT)

  Note: These services are covered under the medical component of your plan.

- Weight reduction or control programs, special foods, food supplements, liquid diets, diet plans or any related products or supplies.
- Services or treatment from unlicensed providers, including pastoral counselors (except as required by law), or services or treatment outside the scope of a provider's licensure.
- Personal convenience or comfort items, including but not limited to TVs, telephones, computers, beauty or barber services, exercise equipment, air purifiers, or air conditioners.
- Light boxes and other equipment, including durable medical equipment, whether associated with a behavioral or non-behavioral condition.
- Private duty nursing services while you are confined in a facility.
- Surgical procedures including but not limited to gender reassignment surgery.

  Note: The medical component of your plan provides coverage for many surgical procedures, including gender reassignment surgery.

- Smoking cessation related services and supplies.

  Note: These services and supplies are covered under the medical and prescription drug components of your plan.

- Travel or transportation expenses, unless Beacon has requested and arranged for you to be transferred by ambulance from one facility to another.
- Services performed by a provider who is your family member by birth or marriage, including a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with the same legal residence as you.
- Mental health and substance use disorder services that you have no legal responsibility to pay, or that would not ordinarily be charged in the absence of coverage under the plan.
- Charges in excess of any specified plan limitations.
- Charges for missed appointments.
- Charges for record processing, except as required by law.
- Services provided under another plan, or services or treatment that must be purchased or provided through other arrangements under federal, state or local law. This includes but is not limited to coverage required by workers' compensation, no-fault auto insurance, or similar legislation. Benefits will not be paid if you could have elected workers' compensation or coverage under a similar law (or could have it elected for you).
- Behavioral health services received as a result of war or any act of war (declared or undeclared) or caused during service in the armed forces of any country when you are legally entitled to other coverage.
- Treatment or services received prior to your eligibility for coverage under the plan or after your coverage under the plan ends.

Part III – Definitions, Appeals, Complaints and Grievances

Definitions of Beacon Health Options Behavioral Health Terms

Allowed amounts – The maximum amount Beacon will reimburse for services or treatment. Beacon's allowed amounts can be based on "reasonable and customary fees," a percentage of Medicare, or negotiated fee maximums. If your out-of-network provider or facility charges more than these allowed amounts, you may be responsible for the difference, in addition to any amount not covered by the benefit. Out-of-network rates or allowed amounts are not contracted rates and are subject to change at any time without notification.

Appeal – A formal request for Beacon to reconsider any adverse determination or denial of coverage for admissions, continued stays, levels of care, procedures or services. Appeals can occur either concurrently or retrospectively.

Beacon Health Options (Beacon) clinician – A licensed master's level or registered nurse behavioral health clinician who provides prior authorization for EAP, mental health and substance use disorder services. Beacon clinicians have three or more years of clinical experience, Certified Employee Assistance Professionals (CEAP) certification or eligibility, and a comprehensive understanding of the full range of EAP services.

Case management – Beacon's clinical case managers can help support you and your family by helping to determine the appropriate treatment; reviewing your case; coordinating benefits and services; providing available resources; working with your providers; encouraging development of a care plan; and/or providing psychoeducation.

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

Complaint – A verbal or written statement of dissatisfaction to Beacon concerning a perceived adverse administrative action, decision or policy.

Continuing review or concurrent review – A clinical case manager works closely with the provider to determine the appropriateness of continued care, review the current treatment plan and progress, and discuss your future care needs.

Coordination of Benefits (COB) – You and your dependents may be entitled to receive benefits from more than one plan. When this occurs, your plans use coordination of benefits (COB) to determine the order and proportion of coverage for your mental health and substance use disorder benefits. COB regulations determine which insurer has primary responsibility for payment and pays first, and which insurer has secondary responsibility for any charges not covered by the primary plan.

Copayment (copay) – A set amount you pay when you get certain mental health or substance use disorder services.

Cost sharing – The amount that you pay for the cost of services. This includes any applicable copays and deductibles.

Covered services – Services and supplies provided for the purpose of preventing, diagnosing or treating a behavioral disorder, psychological injury or substance use disorder. Covered services are described in "What This Plan Pays: Summary of Covered Services." The items under "What's Not Covered – Exclusions" are **not** covered services.

Deductible – A set amount you pay for certain mental health and substance use disorder services each plan year before Beacon starts paying for those services. Your deductible starts on July 1 each year.

Intermediate care – Care that is more intensive than traditional outpatient treatment but less intensive than 24-hour hospitalization. This includes, but is not limited to, partial hospitalization programs and acute residential withdrawal management.

In-network provider – A provider that participates in the Beacon network.

Member – A person who is enrolled in this plan through the Group Insurance Commission.

Non-routine services – Specialty services that require prior authorization. Non-routine services include:

- ❑ Individual/family outpatient therapy visits (including therapy conducted in conjunction with medication visits) beyond 26 visits per member in a year.
- ❑ Intensive outpatient treatment programs provided by a non-Massachusetts DPH-licensed provider
- ❑ Electroconvulsive treatment (ECT)

> **Note:** Professional anesthesia services are covered under the medical component of your plan.

- ❑ Psychological testing
- ❑ Neuropsychological testing for a mental health condition
- ❑ Applied Behavior Analysis (ABA)
- ❑ Transcranial Magnetic Stimulation (TMS)
- ❑ Acupuncture withdrawal management provided by a non-Massachusetts DPH-licensed provider
- ❑ Ambulatory withdrawal management provided by a non-Massachusetts DPH-licensed provider
- ❑ Community support programs
- ❑ Day treatment
- ❑ Dialectical Behavioral Therapy (DBT)
- ❑ Enrollee Assistance Program (EAP)
- ❑ Family stabilization team (FST)
- ❑ Psychiatric visiting nurse services

Out-of-network provider – A provider that does not participate in the Beacon network.

Out-of-pocket limit – The maximum amount you will pay in coinsurance, deductibles and copays for your medical, mental health and substance use disorder care in one plan year. When you have met your out-of-pocket limit, all care will be covered at 100% of the allowed amount until the end of the year. This limit does not include charges for out-of-network care that exceed the maximum number of covered days or visits, charges for care that is not a covered service, or charges in excess of Beacon's allowed amounts.

Prior authorization – The process of contacting Beacon prior to seeking non-routine mental health or substance use disorder care, or for a referral to Enrollee Assistance Program (EAP) services. All prior authorization is performed by Beacon clinicians.

Routine services – A customary service that does not require prior authorization. Routine services include outpatient therapy (individual/family and telehealth counseling), up to 26 visits per member in a year, including therapy done in conjunction with medication management visits; group therapy of 45 to 50 minutes in duration; medication management and telehealth medication management; methadone maintenance; in-network urine drug screening as a medically necessary part of substance use disorder treatment; and emergency service programs (ESP). Outpatient therapy visits over 26 per year are considered non-routine and require prior authorization.

Filing Claims

In-network providers and facilities will file your claim for you. You are financially responsible for in-network copays.

Out-of-network providers are not required to process claims on your behalf; you may have to submit the claims yourself. You are responsible for your out-of-network deductible and copays. **If you are required to submit the claim yourself**, you can send a completed CMS 1500 claim form, along with the out of network provider's itemized bill, with your name, address and GIC ID number, to the following address:

Beacon Health Options
500 Unicorn Park Drive
Suite 103
Woburn, MA 01801

You may also submit a claim for reimbursement through our online portal: mybeacon.beaconhs.com or on a completed Member Reimbursement claim form, along with proof of payment, to the following address:

Beacon Health Options
GIC Member Reimbursements
PO Box 527
Woburn, MA 01801

The CMS 1500 form is available from your provider or at beaconhealthoptions.com/gic. The Member Reimbursement claim form can be found at beaconhealthoptions.com/gic. Beacon must receive all claims within 24 months of the date of service for you or your dependents. You must have been eligible for coverage on the date you received care, and treatment must be medically necessary. All claims are confidential. Please note: if you choose to submit claims via the online portal, and you decide to change health plans, you will need to re-register on the portal with your new member ID.

Complaints

We encourage you to speak with a Beacon customer service representative if you are not satisfied with any aspect of our program. You can reach Beacon at 855-750-8980 (TTY: 711) Monday through Friday from 8 a.m. to 7 p.m. ET. Beacon's member services representatives can resolve most inquiries during your initial call. Inquiries that require further research are reviewed by representatives of the appropriate departments at Beacon, including clinicians, claims representatives, administrators and other managers who report directly to senior corporate officers. We will respond to all inquiries within three business days.

We want to hear from you. Your comments will help us correct any problems and provide better service to you and your dependents. If the resolution of your inquiry is unsatisfactory to you, you have the right to file a formal written complaint within 60 days of the date of our telephone call or letter of response. Beacon will respond to all formal complaints in writing within 30 days.

To submit a formal written complaint regarding a mental health or substance use disorder concern, please contact:

Ombudsperson
Beacon Health Options
500 Unicorn Park Drive
Suite 103
Woburn, MA 01801

Formal written complaints should include any information you feel is relevant. Please specify the dates of service and any additional contact you have had with Beacon.

Appeals

Your Right to an Internal Appeal

You, your treating provider, or someone acting on your behalf has the right to request an appeal of Beacon's benefit decisions. You may request an appeal by following the steps below.

> **Note:** If your care needs are urgent (meaning that a delay in making a treatment decision could significantly increase your health risks or affect your ability to regain maximum functioning), please see the section below titled "How to Initiate an Urgently Needed Determination (Urgent Appeal)."

How to Initiate a First Level Internal Appeal (Non-Urgent Appeal)

Your appeal request must be submitted to Beacon within 180 calendar days of your receipt of the notice of the coverage denial.

Written requests should be submitted to the following address:

Beacon Health Options
Appeals Department
500 Unicorn Park Drive
Suite 103
Woburn, MA 01801
855-750-8980 (TTY: 711)
Fax: 781-994-7636

Appeal requests must include:

- ❑ The member's name and identification number
- ❑ The date(s) of service(s)
- ❑ The provider's name
- ❑ The reason you believe the claim should be paid
- ❑ Any documentation or other written information to support your request for claim payment

The Appeal Review Process (Non-Urgent Appeal)

If you request an appeal review of a denial of coverage, the review will be conducted by someone who was not involved in the initial coverage denial, and who is not a subordinate to the person who issued the initial coverage denial.

For a non-urgent appeal review, a Beacon clinician will review the denial and notify you of the decision, in writing, within 15 calendar days of your request.

For an appeal review of a denial of coverage that has already been provided to you, Beacon will review the denial and will notify you in writing of Beacon's decision within 30 calendar days of your request.

You may bypass Beacon's internal review process and request an external review by an independent review organization, which will review your case and make a final decision, if Beacon exceeds the time requirements for making a determination and providing notice of the decision.

If Beacon continues to deny the payment, coverage or service requested, you may request an external review by an independent review organization, that will review your case and make a final decision. This process is described in the "Independent External Review Process (Non-Urgent Appeal)" section below.

Independent External Review Process (Non-Urgent Appeal)

You have the right to request an external review by an Independent Review Organization (IRO) of a decision made to not provide you a benefit or pay for an item or service (in whole or in part). Beacon is required by law to accept the determination of the IRO in this external review process.

You, your provider, or someone you consent to act for you (your authorized representative) can make this request. Requests must be made in writing within 180 calendar days of receipt of your non-coverage determination notice.

Written requests for independent external review should be submitted to the following address:

Beacon Health Options
Appeals Department
500 Unicorn Park Drive
Suite 103
Woburn, MA 01801
855-750-8980 (TTY: 711)
Fax: 781-994-7636

Independent External Review requests must include:

- ❑ Your name and identification number
- ❑ The dates of service that were denied
- ❑ Your provider's name
- ❑ Any information you would like to be considered, such as records related to your current symptoms and treatment, co-existing conditions, or any other relevant information you believe supports your appeal

If you request an independent external review, Beacon will complete a preliminary review within five business days to determine whether your request is complete and eligible for an independent external review.

Additional information about this process, and your member rights and appeal information, is available at beaconhealthoptions.com/gic or by speaking with a Beacon representative.

How to Initiate an Urgently Needed Determination (Urgent Appeal)

In general, an urgent situation is one in which your health may be in serious jeopardy, or in which your provider believes that delaying a treatment decision may significantly increase your health risks or affect your ability to regain maximum function. If you believe that your situation is urgent, contact Beacon immediately to request an urgent review. If your situation meets the definition of urgent, Beacon will conduct the review on an expedited basis.

You may also request that an independent third party conduct a separate urgent review (see below) at the same time. You, your provider, or your authorized representative may request a review. Contact Beacon if you wish to name an authorized representative to request a review on your behalf.

Beacon will make a determination and notify you verbally and in writing within 72 hours of your request for an urgent review. If Beacon continues to deny the payment, coverage or service requested, you may request an external review by an independent review organization that will review your case and make a final decision. This process is described in the "Independent External Review Process (Urgent Appeal)" section below.

Independent External Review Process (Urgent Appeal)

You have a right to request an external review by an Independent Review Organization (IRO) of a decision made to not provide you a benefit or pay for an item or service (in whole or in part). Beacon is legally required to accept the determination of the IRO in this external review process.

You, your provider or your authorized representative may make a request. Requests must be made in writing within 180 calendar days of receipt of your non-coverage determination notice.

Written requests for independent external review should be submitted to the following address:

Beacon Health Options
Appeals Department
500 Unicorn Park Drive
Suite 103
Woburn, MA 01801
855-750-8980 (TTY: 711)
Fax: 781-994-7636

Independent External Review requests must include:

- ❑ Your name and identification number
- ❑ The dates of service that were denied
- ❑ Your provider's name
- ❑ Any information you would like to have considered, such as records related to the current conditions of treatment, co-existent conditions or other relevant information

If you request an independent external review for an urgent request, Beacon will complete an immediate preliminary review to determine whether your request is complete and eligible for an independent external review.

You can find additional information about this process and your member rights and appeal information at beaconhealthoptions.com/gic. You can also call 855-750-8980 (TTY: 711) to speak with a Beacon representative.

APPENDICES

Appendix A: GIC Notices

Appendix B: Tier Designations for Massachusetts Hospitals

Appendix C: Forms

Appendix D: Federal and State Mandates

Appendix E: Your Right to Appeal

Appendix A: GIC Notices

- ❑ Notice of Group Insurance Commission (GIC) Privacy Practices
- ❑ Important notice from the GIC about your prescription drug coverage and Medicare
- ❑ The Uniformed Services Employment and Reemployment Rights Act (USERRA)

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/PLUS and your options under Medicare's prescription drug coverage. This information can help you decide whether or not to join a non-GIC Medicare drug plan. If you are considering joining a non-GIC plan, you should compare your current coverage – particularly which drugs are covered, and at what cost – with that of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage can be found at the end of this notice.

For most people, the drug coverage that you currently have through your GIC health plan is a better value than the Medicare drug plans.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available to everyone with Medicare in 2006. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The GIC has determined that the prescription drug coverage offered by your plan is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Part D drug plan.

When can you join a Medicare Part D drug plan?

You can join a non-GIC Medicare drug plan when you first become eligible for Medicare and each subsequent year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two month Special Enrollment Period to join a non-GIC Medicare drug plan.

What happens to your current coverage if you decide to join a non-GIC Medicare drug plan?

- ❑ If you enroll in another Medicare prescription drug plan or a Medicare Advantage plan with or without prescription drug coverage, you will be disenrolled from the GIC-sponsored CVS Caremark plan. If you are disenrolled from CVS Caremark, you will lose your GIC medical, prescription drug, and behavioral health coverage.

- If you are the insured and decide to join a non-GIC Medicare drug plan, both you and your covered spouse/dependents will lose your GIC medical, prescription drug, and behavioral health coverage.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available online at **www.socialsecurity.gov** or by phone at 800-772-1213 (TTY: 800-325-0778).

When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with a GIC plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this notice or your current prescription drug coverage …

Contact the GIC at 617-727-2310, extension 1.

> **Note:** You will receive this notice each year and if this coverage through the Group Insurance Commission changes. You may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage ...

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the *Medicare & You* handbook for the telephone number) for personalized help.
- Call 800-MEDICARE (800-633-4227); TTY users should call 877-486-2048.

If you have limited income and assets, extra help paying for Medicare prescription drug coverage is available. For information about the Extra Help program, visit Social Security online at **www.socialsecurity.gov** or call 800-772-1213 (TTY: 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents while in the military.
- Service members who elect to continue their GIC health coverage are required to pay the employee's share for such coverage.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **866-4-USA-DOL** or visit its website at **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: Tier Designations for Massachusetts Hospitals

As a PLUS member, you can use any Massachusetts hospital, which are designated by their tier (Tier 1, 2 or 3). PLUS members who live in Connecticut, Maine, New Hampshire and Rhode Island can use UniCare network hospitals in their state at the $500 inpatient hospital quarterly copay. For hospitals in those states, select *Look for health care providers* on the *Members* page of unicarestateplan.com. Or call UniCare Customer Service at 800-442-9300.

PLUS Tier 1 hospitals

Addison Gilbert Hospital
Anna Jaques Hospital
Athol Memorial Hospital
Baystate Franklin Medical Center
Baystate Medical Center
Berkshire Medical Center
Beverly Hospital
Brockton Hospital
Cambridge Hospital
Cape Cod Hospital
Carney Hospital
Charlton Memorial Hospital
Emerson Hospital
Everett Hospital
(*formerly Whidden Hospital*)
Fairview Hospital
Framingham Union Hospital
Good Samaritan Medical Center
Harrington Memorial Hospital
Heywood Hospital
Holy Family Hospital – Methuen
Holyoke Medical Center
Lawrence General Hospital
Lawrence Memorial Hospital
Leonard Morse Hospital
Lowell General Hospital
Mary Lane Hospital (Baystate)
Melrose-Wakefield Hospital
Mercy Medical Center
Merrimack Valley Hospital (Holy Family)
Milford Regional Medical Center
Morton Hospital
Mount Auburn Hospital
Nashoba Valley Medical Center
Noble Hospital (Baystate)
Norwood Hospital
Saint Vincent Hospital
Saints Medical Center
South Shore Hospital
St. Anne's Hospital
St. Elizabeth's Medical Center
St Luke's Hospital
Sturdy Memorial Hospital
Tobey Hospital
Winchester Hospital
Wing Hospital (Baystate)

PLUS Tier 2 hospitals

Beth Israel Deaconess Medical Center – Boston
Burbank Hospital (HealthAlliance)
Children's Hospital Boston
Clinton Hospital
Cooley Dickinson Hospital
Dana-Farber Cancer Institute
Falmouth Hospital
Leominster Hospital (HealthAlliance)
Marlborough Hospital
Martha's Vineyard Hospital
Massachusetts Eye and Ear
Milton Hospital (Beth Israel Deaconess)
Nantucket Cottage Hospital
Needham Hospital (Beth Israel Deaconess)
New England Baptist Hospital
Plymouth Hospital (Beth Israel Deaconess)
UMass Memorial Medical Center

PLUS Tier 3 hospitals

Boston Medical Center
Brigham and Women's Hospital
Faulkner Hospital (Brigham and Women's)
Lahey Hospital & Medical Center – Burlington
Lahey Medical Center – Peabody
Massachusetts General Hospital
Newton-Wellesley Hospital
North Shore Medical Center – MassGeneral for Children
Salem Hospital
Tufts Medical Center and Floating Hospital for Children
Union Hospital

Appendix C: Forms

This appendix contains the following forms:

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

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

If you don't have access to a computer, you can request forms by calling UniCare Customer Service at 800-442-9300.

Fitness Club Reimbursement Form

What information do I need to provide?

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

What else do I need to know?

- ❑ See "Fitness club reimbursement" on page 50 for details about what is covered under the fitness club reimbursement benefit.
- ❑ Write your UniCare member ID number prominently on all the receipts and documents that you are sending to UniCare and keep copies of all your paperwork for your records.
- ❑ We suggest that you send proof of payment for the full amount instead of making several requests for lesser amounts.
- ❑ Call UniCare Customer Service at 800-442-9300 if you have any other questions.

1. Enrollee name (Last, First, MI)	**2. Enrollee address**
3. Member ID (from UniCare ID card)	
4. Enrollee birth date	**5. Member name (if different from enrollee)**
6. Name of fitness club	**7. Member's relationship to enrollee**
8. Requested reimbursement amount **$**	**9. Reimbursement applies to what plan year?**

Write your member ID on all paperwork. Send this form,
a copy of the fitness club membership, and proof of payment to:

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

Bill Checker Program Form

What is the Bill Checker program?

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

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

What else do I need to know?

- ❑ See "Checking your claims for billing accuracy" on page 96 for details about the Bill Checker program.
- ❑ Send the completed Bill Checker form, along with copies of the original and corrected bills, to the address shown at the bottom of this page.
- ❑ Write your UniCare member ID number prominently on all the documents that you are sending to UniCare and keep copies for your own records.
- ❑ Note that duplicate claims and services are not covered by UniCare and will not be reviewed.
- ❑ Call UniCare Customer Service at 800-442-9300 if you have any other questions.

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

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

UniCare Customer Service Center
PO Box 9016
Andover, MA 01810-0916

Appendix D: Federal and State Mandates

- ❑ Premium assistance under Medicaid and the Children's Health Insurance Program (CHIP)
- ❑ Coverage for reconstructive breast surgery
- ❑ Minimum maternity confinement benefits

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums.
The following list of states is current as of January 31, 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 Customer Service at 800-442-9300 if you have questions.

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 186.

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។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ 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.

Notes

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To find out about ...

UniCare®

An Anthem Company

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