

PLAN BENEFITS – PLUS

Effective July 1, 2023

Summary of PLUS plan benefits

This summary shows the PLUS plan benefits for many medical and behavioral health services. For a complete and detailed description of benefits and Plan provisions, see your member handbook.

- ❑ **Deductibles** – The **PLUS deductible**, which applies to services from PLUS providers, is \$500 for one person or \$1,000 for a family each plan year. The separate **non-PLUS deductible** of \$500 for one person – or \$1,000 for a family – applies to services from non-PLUS providers.
- ❑ **Out-of-pocket cost limits** – The **PLUS out-of-pocket maximum** (\$5,000 for one person and \$10,000 for a family) limits your costs for services with PLUS providers. The separate **non-PLUS out-of-pocket maximum** (\$5,000 and \$10,000) limits your costs with non-PLUS providers.
- ❑ **Allowed amounts** – All benefits shown in this summary are limited to UniCare’s allowed amounts. The allowed amount is the most that UniCare pays for a covered service.
- ❑ **Preapprovals** – Services marked with a 📞 phone symbol need to be preapproved.

Benefits for medical care under PLUS

Service	Your member costs with PLUS providers	Your member costs with non-PLUS providers
 Ambulances	PLUS deductible	PLUS deductible
Anesthesia	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Bereavement counseling	PLUS deductible and 20% coinsurance <i>(limited to \$1,500 for a family in a plan year)</i>	Non-PLUS deductible and 20% coinsurance <i>(limited to \$1,500 for a family a plan year)</i>
Cardiac rehab programs	\$20 copay	Non-PLUS deductible and 20% coinsurance
Chemotherapy	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Chiropractic care	\$20 copay <i>(limited to 20 visits in a plan year)</i>	Non-PLUS deductible and 20% coinsurance <i>(limited to 20 visits in a plan year)</i>
Diabetic supplies	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Dialysis	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Doctor visits		
▪ PCP visits	\$10/20/40 copay	Non-PLUS deductible and 20% coinsurance
▪ Specialist visits	\$30/60/75 copay	Non-PLUS deductible and 20% coinsurance
▪ Virtual care (telehealth)	\$10 copay	Non-PLUS deductible and 20% coinsurance
Doctors – other services		
▪ At an emergency room	PLUS deductible	PLUS deductible
▪ Inpatient hospital care	PLUS deductible	Non-PLUS deductible and 20% coinsurance
▪ Outpatient hospital care	\$30/60/75 copay	Non-PLUS deductible and 20% coinsurance

Service	Your member costs with PLUS providers	Your member costs with non-PLUS providers
Drug screening (lab tests)	PLUS deductible	Non-PLUS deductible and 20% coinsurance
 Durable medical equipment (DME)	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Early intervention programs	No member costs	No member costs
Emergency room visits	\$100 copay and PLUS deductible	\$100 copay and PLUS deductible
 Enteral therapy	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Eye exams (routine)	\$30/60/75 copay (limited to one exam every 24 months)	Non-PLUS deductible and 20% coinsurance (limited to one exam every 24 months)
Eyeglasses and contact lenses	PLUS deductible (limited to the first lenses within six months after eye injury or cataract surgery)	PLUS deductible (limited to the first lenses within six months after eye injury or cataract surgery)
Family planning services	No member costs	No member costs
Fitness club reimbursement	Reimbursed up to \$100 for the family in a plan year	Reimbursed up to \$100 for the family in a plan year
Hearing aids		
▪ Age 21 and under	No member costs (limited to \$2,000 for each impaired ear every 24 months)	No member costs (limited to \$2,000 for each impaired ear every 24 months)
▪ Age 22 and over	No member costs (limited to \$1,700 for each impaired ear every 24 months)	No member costs (limited to \$1,700 for each impaired ear every 24 months)
Hearing exams	No member costs (but you may owe a copay for the office visit)	Non-PLUS deductible and 20% coinsurance
 High-tech imaging (e.g., MRIs, CT and PET scans)		
▪ Inpatient hospital	PLUS deductible	Non-PLUS deductible and 20% coinsurance
▪ Outpatient hospital and non-hospital-owned locations	\$100 daily copay and PLUS deductible	\$100 daily copay, non-PLUS deductible, and 20% coinsurance
 Home health care	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Home infusion therapy	PLUS deductible	Non-PLUS deductible and 20% coinsurance
 Hospice care	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Immunizations (vaccines)	No member costs (but you may owe a copay for the office visit)	No member costs (but you may owe a copay for the office visit)
 Inpatient medical care		
▪ At a hospital or rehab facility (semi-private room)	\$275/500/1,500 quarterly copay and PLUS deductible (\$500 copay outside of MA)	Non-PLUS deductible and 20% coinsurance
▪ At a hospital or rehab facility (medically necessary private room)	<ul style="list-style-type: none"> ▪ First 90 days: \$275/500/1,500 quarterly copay and PLUS deductible (\$500 copay outside of MA) ▪ After 90 days: Dollar difference between the semi-private room rate and the private room rate 	<ul style="list-style-type: none"> ▪ First 90 days: Non-PLUS deductible and 20% coinsurance ▪ After 90 days: 20% coinsurance, and the dollar difference between the semi-private room rate and the private room rate

Service	Your member costs with PLUS providers	Your member costs with non-PLUS providers
Inpatient medical care (cont.) <ul style="list-style-type: none"> ▪ Neonatal ICU 	<ul style="list-style-type: none"> ▪ At a designated hospital: \$275 quarterly - copay and PLUS deductible ▪ At other hospitals: \$275/500/1,500 quarterly copay and PLUS deductible (\$500 copay outside of MA) 	<ul style="list-style-type: none"> ▪ At a designated hospital: \$275 quarterly copay and PLUS deductible ▪ At other hospitals: Non-PLUS deductible and 20% coinsurance
Lab services	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Occupational therapy	\$20 copay (limited to 30 visits in a plan year except with autism diagnosis)	Non-PLUS deductible and 20% coinsurance (limited to 30 visits in a plan year except with autism diagnosis)
Office visits	See “Doctor visits” on page 1.	
Oxygen	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Personal Emergency Response Systems (PERS) <ul style="list-style-type: none"> ▪ Installation 	PLUS deductible and 20% coinsurance (limited to \$50 in a plan year)	PLUS deductible and 20% coinsurance (limited to \$50 in a plan year)
<ul style="list-style-type: none"> ▪ Rental 	PLUS deductible and 20% coinsurance (limited to \$40 a month)	PLUS deductible and 20% coinsurance (limited to \$40 a month)
Physical therapy	\$20 copay (limited to 30 visits in a plan year except with autism diagnosis)	Non-PLUS deductible and 20% coinsurance (limited to 30 visits in a plan year except with autism diagnosis)
Prescription drugs	<ul style="list-style-type: none"> ▪ From a network pharmacy (30-day supply): \$10/30/65 copay ▪ By mail order (90-day supply): \$25/75/165 <p style="text-align: center;"><i>Benefits administered by CVS Caremark. Call 877-876-7214 for information.</i></p>	
Preventive care	No member costs	No member costs
Prosthetics and orthotics	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Radiation therapy	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Radiology (e.g., X-rays) <ul style="list-style-type: none"> ▪ Inpatient hospital 	PLUS deductible	Non-PLUS deductible and 20% coinsurance
<ul style="list-style-type: none"> ▪ Outpatient hospital and non-hospital-owned locations 	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Retail health clinic visits	\$20 copay	\$20 copay
Skilled nursing and long-term care facilities	PLUS deductible and 20% coinsurance (limited to 100 days in a plan year)	PLUS deductible and 20% coinsurance (limited to 100 days in a plan year)
Sleep studies	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Speech therapy	\$20 copay	Non-PLUS deductible and 20% coinsurance
Surgery – inpatient hospital	PLUS deductible (you also have an inpatient copay; see “Inpatient services”)	Non-PLUS deductible and 20% coinsurance

Service	Your member costs with PLUS providers	Your member costs with non-PLUS providers
📞 Surgery – outpatient		
▪ At a hospital	\$250 quarterly copay and PLUS deductible	Non-PLUS deductible and 20% coinsurance
▪ Eye and GI surgery at a non-hospital-owned facility	\$150 quarterly copay and PLUS deductible	Non-PLUS deductible and 20% coinsurance
▪ All other outpatient surgery at a non-hospital-owned facility	\$250 quarterly copay and PLUS deductible	Non-PLUS deductible and 20% coinsurance
▪ At a doctor’s office	Deductible (<i>you may also owe a copay for the office visit</i>)	Non-PLUS deductible and 20% coinsurance
Tobacco cessation counseling	No member costs (<i>limited to 300 minutes in a plan year</i>)	No member costs (<i>limited to 300 minutes in a plan year</i>)
📞 Transplants		
▪ At a Quality Center or Designated Hospital for transplants	\$275/500/1,500 quarterly copay and PLUS deductible	\$275/500/1,500 quarterly copay and PLUS deductible
▪ At other hospitals	\$275/500/1,500 quarterly copay, PLUS deductible, and 20% coinsurance	Non-PLUS deductible and 20% coinsurance
Urgent care center visits	\$20 copay	\$20 copay
Virtual care (telehealth)	\$10 copay	Non-PLUS deductible and 20% coinsurance
Wigs (after cancer treatment)	20% coinsurance	20% coinsurance

Benefits for behavioral health care under PLUS

Service	Your member costs with PLUS providers	Your member costs with non-PLUS providers
📞 Applied Behavior Analysis (ABA)	\$10 copay	Non-PLUS deductible and 20% coinsurance
Emergency service programs	No member costs	No member costs
📞 Inpatient behavioral health care		
▪ Facility charges	\$275 quarterly copay and PLUS deductible	Non-PLUS deductible and 20% coinsurance
▪ Professional services	No member costs	Non-PLUS deductible and 20% coinsurance
Medication-assisted treatment	No member costs	No member costs
📞 Outpatient services		
▪ Acupuncture withdrawal management (detox)	\$20 copay	Non-PLUS deductible and 20% coinsurance
▪ All other outpatient services	\$10 copay	Non-PLUS deductible and 20% coinsurance
Substance use disorder assessment / referral	No member costs	No member costs
Therapy	\$10 copay	Non-PLUS deductible and 20% coinsurance
Virtual care (telehealth)	\$10 copay <i>You don't owe a copay for the first 3 visits.</i>	Non-PLUS deductible and 20% coinsurance