PLAN BENEFITS – TOTAL CHOICE

Effective July 1, 2023

Summary of Total Choice benefits

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

- **Deductible** – The Total Choice plan deductible is $500 for one person or $1,000 for a family each plan year.
- **Out-of-pocket cost limits** – The **out-of-pocket maximum** ($5,000 for one person and $10,000 for a family) limits your costs for medical, behavioral health, and pharmacy services.
- **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 Total Choice

Service	Your member costs
☎ **Ambulances**	Deductible
Anesthesia	Deductible
Bereavement counseling	Deductible and 20% coinsurance *(limited to $1,500 for a family in a plan year)*
Cardiac rehab programs	$20 copay
Chemotherapy	Deductible
Chiropractic care	$20 copay *(limited to 20 visits in a plan year)*
Diabetic supplies	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance
Dialysis	Deductible
Doctor visits	
▪ Primary care (PCP) visits	$20 copay
▪ Specialist visits	$45 copay
▪ Virtual care (telehealth)	$20 copay
Doctors – other services	
▪ At an emergency room	Deductible
▪ Inpatient hospital care	Deductible
▪ Outpatient hospital care	$45 copay
Drug screening (lab tests)	Deductible
☎ **Durable medical equipment (DME)**	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance

Service	Your member costs
Early intervention programs	No member costs
Emergency room visits	$100 copay and deductible
☎ **Enteral therapy**	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance
Eye exams (routine)	$45 copay *(limited to one exam every 24 months)*
Eyeglasses and contact lenses	Deductible *(limited to the first lenses within six months after eye injury or cataract surgery)*
Family planning services	No member costs
Fitness reimbursement	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)*
▪ Age 22 and over	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)*
☎ **High-tech imaging (e.g., MRIs, CT scans, and PET scans)**	
▪ Inpatient hospital	Deductible
▪ Outpatient hospital and non-hospital-owned facilities	$100 daily copay and deductible
☎ **Home health care**	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance
Home infusion therapy	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance
☎ **Hospice care**	Deductible
Immunizations (vaccines)	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 quarterly copay and deductible
▪ At a hospital or rehab facility (medically necessary private room)	▪ **First 90 days:** $275 quarterly copay and deductible ▪ **After 90 days:** Dollar difference between the semi-private room rate and the private room rate
Lab services	Deductible
☎ **Occupational therapy**	$20 copay *(limited to 30 visits in a plan year except with autism diagnosis)*
Office visits	*See "Doctor visits" on page 1.*
Oxygen	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance
Personal Emergency Response System (PERS)	
▪ Installation	Deductible and 20% coinsurance *(limited to $50 in a plan year)*
▪ Rental	Deductible and 20% coinsurance *(limited to $40 a month)*

Service	Your member costs
☎ **Physical therapy**	$20 copay *(limited to 30 visits in a plan year except with autism diagnosis)*
Prescription drugs *Benefits administered by CVS Caremark.* *Call 877-876-7214 for information.*	▪ From a network pharmacy (30-day supply): $10/30/65 copay ▪ By mail order (90-day supply): $25/75/165
Preventive care	No member costs
☎ **Prosthetics and orthotics**	Deductible
☎ **Radiation therapy**	Deductible
Radiology (e.g., X-rays)	
▪ Inpatient hospital	Deductible
▪ Outpatient hospital and non-hospital-owned facilities	Deductible
Retail health clinic visits	$20 copay
☎ **Skilled nursing and long-term care facilities**	Deductible and 20% coinsurance *(limited to 100 days in a plan year)*
☎ **Sleep studies**	Deductible
☎ **Speech therapy**	$20 copay
☎ **Surgery – inpatient hospital**	Deductible *(you also have an inpatient copay; see "Inpatient services")*
☎ **Surgery – outpatient**	
▪ At a hospital	$250 quarterly copay and deductible
▪ Eye and GI (gastrointestinal) surgery at a non-hospital-owned facility	$150 quarterly copay and deductible
▪ All other outpatient surgery at a non-hospital-owned facility	$250 quarterly copay and deductible
▪ At a doctor's office	Deductible *(you may also owe a copay for the office visit)*
Tobacco cessation counseling	No member costs *(limited to 300 minutes in a plan year)*
☎ **Transplants**	
▪ At a Quality Center or Designated Hospital for transplants	$275 quarterly copay and deductible
▪ At other hospitals	$275 quarterly copay, deductible, and 20% coinsurance
Urgent care center visits	$20 copay
Virtual care (telehealth)	$20 copay
Wigs (after cancer treatment)	20% coinsurance

Benefits for behavioral health care under Total Choice

Service	Your member costs with contracted providers	Your member costs with non-contracted providers
☎ **Applied Behavior Analysis (ABA)**	$20 copay	Deductible and 20% coinsurance
Emergency service programs	No member costs	No member costs
☎ **Inpatient behavioral health care**		
▪ Facility charges	$275 quarterly copay and deductible	Deductible and 20% coinsurance
▪ Professional services	No member costs	Deductible and 20% coinsurance
Medication-assisted treatment (MAT)	No member costs	No member costs
☎ **Outpatient services**	$20 copay	Deductible and 20% coinsurance
Substance use disorder assessment / referral	No member costs	No member costs
Therapy	$20 copay	Deductible and 20% coinsurance
Virtual care (telehealth)	$20 copay *You don't owe a copay for the first 3 visits.*	Deductible and 20% coinsurance