SERIES 2

UNICARE STATE INDEMNITY PLAN

MEDICARE EXTENSION

Member Handbook for Medicare Retirees

Effective July 1, 2023

UniCare℠

Commonwealth of Massachusetts
Group Insurance Commission

UNICARE STATE INDEMNITY PLAN MEDICARE EXTENSION MEMBER HANDBOOK

For Medicare retirees

Effective July 1, 2023 - June 30, 2024

UniCare℠

Disclosure when Plan Meets Minimum Standards

*This health plan **meets the Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance. Please see additional information below.*

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2008, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

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

THIS DISCLOSURE IS FOR THE MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2018. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIALS EACH YEAR TO DETERMINE WHETHER YOUR HEALTH PLAN MEETS THE LATEST STANDARDS.

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

Interpreting and Translating Services

If you need a language interpreter when you call UniCare Member Services, a member 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.

Whom to Contact

Questions about medical or behavioral health coverage

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

- **Member Services:**
  800-442-9300 / TTY: 711 (toll free)
  7:30 a.m. to 6:00 p.m. (M-Th)
  7:30 a.m. to 5:00 p.m. (F)
- **Email:**
  contact.us@anthem.com
- **Website:**
  unicaremass.com

If you call after business hours, you can leave a message. Member Services will return your call on the next business day.

For questions about:

- Benefits for a medical service or procedure
- Benefits for mental health or substance use disorder services
- Status of a medical or behavioral health claim
- Finding a doctor, hospital, or other healthcare provider
- These sections of this handbook:
  - Part 1: Getting Started (pages 11-24)
  - Part 2: Your Medical Benefits (pages 25-71)
  - Part 3: Your Behavioral Health Benefits (pages 73-88)
  - Part 4: Using Your Plan (pages 89-135)

Questions about prescription drug coverage

SilverScript

- **Customer Service:**
  877-876-7214 / TTY: 711 (toll free)
- **Website:**
  gic.silverscript.com

For questions about:

- Benefits for a prescription drug
- Status of a prescription drug claim
- Where to get prescriptions filled
- Which drugs are covered
- This section of this handbook:
  - Part 5: Your Prescription Drug Plan (pages 137-144)

If you have other questions, including questions about premiums or participation in any Group Insurance Commission (GIC) programs, please fill out the GIC's online contact form available at https://www.mass.gov/forms/contact-the-gic.

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PART 1:

GETTING STARTED

Introducing Medicare Extension

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

Administered by

UniCare℠

Chapter 1: First things first

Be sure to read this handbook carefully to learn about the benefits and features of your Plan. If you have questions, see the contact information on page 3.

About this plan

Introducing the Medicare Extension plan

This handbook is a guide to benefits for you and your Medicare dependents covered under **UniCare State Indemnity Plan/Medicare Extension**.

Your Medicare Extension 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 most administrative services – including claims processing and member services – at its service center in Woburn, Massachusetts. UniCare is not the fiduciary or the insurer of UniCare State Indemnity Plan/Medicare Extension.

The Medicare Extension plan supplements your Medicare coverage by providing you with comprehensive coverage for many health services including hospital stays, surgery, emergency care, preventive care, outpatient services and other medically necessary treatment. You can get services from any provider. Keep in mind, however, that benefits can differ depending on the service and the provider, and that not all services are covered by the Plan.

About your Medicare membership

You must be enrolled in Medicare Part A and Part B to be eligible for the Medicare Extension plan. If you let your Medicare coverage lapse, you will no longer be eligible for benefits under the Medicare Extension plan.

Do not enroll in a non-GIC Medicare Part D product. This plan includes Medicare Part D coverage. If you enroll in another Part D product, the Centers for Medicare and Medicaid Services (CMS) will disenroll you from your GIC coverage. This means that you will lose your GIC health, behavioral health, and prescription drug benefits.

This handbook is not a description of your Medicare benefits. For more information about Medicare, read the *Medicare & You* handbook, which is produced by Medicare and is available from your local Social Security office, or online at www.medicare.gov.

About this handbook

Benefits described in this handbook

This handbook looks at features and coverage for these types of benefits:	
Medical services	These benefits are administered by UniCare
Behavioral health services	These benefits, which cover mental health and substance use disorder services, are administered by UniCare in partnership with **Carelon Behavioral Health**
Prescription drugs	These benefits are separately administered by **SilverScript**

A note about terms and definitions

Definitions for many of the terms used in this handbook appear in Chapter 14 (pages 126-135). You should also keep in mind that:

- ❑ The formal name of your plan is **UniCare State Indemnity Plan/Medicare Extension**. In this handbook and other plan materials, we usually refer to it as the **Medicare Extension plan**, **Medicare Extension**, or **the Plan**.
- ❑ We often use the abbreviation **GIC** for the **Group Insurance Commission**.
- ❑ If you have dependents covered under your plan, text that refers to **you** also applies to your dependents.
- ❑ **Medical services (medical care)** are those services covered by the medical benefits described in Part 2 (pages 25-71). **Behavioral health services** are services to treat mental health and substance use disorders, which are described in Part 3 (pages 73-88). When we're talking about both types of services together, we usually call them **healthcare services**.

Where to find information in this handbook

Part 1: Getting Started	Pages 11-24

- Overview information to help you get to know the health benefits administered by UniCare
- Features and advantages of Medicare Extension
- How to get the most out of your Medicare Extension coverage
- How costs and billing work

Part 2: Your Medical Benefits	Pages 25-71

- Information about preapproval reviews for medical necessity
- Medical services covered under this plan
- What your benefits are for preventive services

Part 3: Your Behavioral Health Benefits	Pages 73-88

- General information about your behavioral health benefits
- When and how to get behavioral health services preapproved, and which services need to be preapproved
- Mental health and substance use disorder services covered under this plan

Part 4: Using Your Plan	Pages 89-135

- How to understand and use the features of Medicare Extension
- Exclusions and limits on what's covered
- Descriptions of the different kinds of healthcare providers
- Information about claims, preapproval reviews, and other health plan concepts

Part 5: Your Prescription Drug Plan	Pages 137-144

- General information about your prescription drug benefits (administered by SilverScript)
- What your coverage is for prescription drugs
- Exclusions and limits on your prescription drug benefits

Part 6: Appendices	Pages 145-170

- Reference material and notices including GIC notices; forms; state and federal mandates; member notices; and the index

Symbols used in this handbook

What the handbook symbols mean	
	**Important information** – This may have an impact on your benefits or costs.
	**No coverage, limited coverage, or benefit restriction** – A full list of Plan exclusions and limitations appears in Chapter 10.
	**May need preapproval review** – This service may need to be reviewed for medical necessity.
	**Use Medicare suppliers or UniCare preferred vendors** – To get the best benefit for this service or product, use a Medicare supplier, if one is available. Otherwise, look for a UniCare preferred vendor. See page 23 to learn more.
	**Use Sydney Health** – You can do this through the Sydney Health app (page 124).
	**Go to unicaremass.com** – This information can be found at our website.

Do you have other health insurance?

If you or a family member has health coverage from an insurer other than UniCare, you may need to fill out and send an *Other Health Insurance (OHI)* form to UniCare.

UniCare needs this information to coordinate your benefits with other plans. To learn more about how this works, turn to “Coordinating benefits with other health plans (COB)” on pages 119-122.

 Find this and other forms at unicaremass.com.

You don’t need to submit an OHI form if…

- ❑ You don’t have coverage under any other health plans, ***or***
- ❑ You do have other coverage, but it’s from AARP, MassHealth, Medicare, or TRICARE, ***or***
- ❑ You’ve already submitted an OHI form and your coverage hasn’t changed.

You do need to submit an OHI form if…

- ❑ You’re covered under another health plan, and that plan is not AARP, MassHealth, Medicare, or TRICARE, ***and***
- ❑ You either haven’t submitted an OHI form before or else the form you submitted previously needs to be updated.

About your ID card

Every Medicare Extension member will get a UniCare ID card. These cards have useful information about your benefits, as well as important telephone numbers you and your healthcare providers may need.

When you need healthcare services, tell your provider that you are a member of both Medicare ***and*** the Medicare Extension plan. Show your provider both your Medicare card and your UniCare ID card.

If you'd prefer to use an electronic ID card instead of a physical card, you can access yours through the Sydney Health app.

You can order replacement physical cards from unicaremass.com.

Your prescription drug card is separate. SilverScript will send your prescription drug cards separately. Call SilverScript at 877-876-7214 if you have questions about your prescription drug card.

Some services may need preapproval review

In some circumstances, UniCare may need to preapprove a service – that is, review the service for medical necessity. This can be necessary if a service isn't covered by Medicare or if your Medicare benefits for that service have been exhausted. Your provider must notify UniCare if you are having a service that requires review.

For more information about preapproval reviews…	
Medical services	See page 26
Behavioral health services – Mental health and substance use disorder services	See pages 75-77

Getting the most out of Medicare Extension

For a description of the different kinds of providers mentioned in the table below, see “Types of healthcare providers” on pages 103-105.

Table 1. How to get the most out of Medicare Extension

Tips on choosing providers		See pages
Use providers who participate in Medicare	Your benefits are best when you use Medicare participating providers – providers who have agreed to accept Medicare’s payment as payment in full for covered services. If you get care outside of Massachusetts, participating providers will not balance bill you for charges over the Plan’s allowed amount, but other providers may do so.	22
Use Carelon Behavioral Health in-network providers for behavioral health services	Carelon Behavioral Health in-network providers won’t balance bill you for charges over the Plan’s allowed amount.	74
If you need care quickly, take advantage of walk-in clinics	You have a $10 copay at walk-in clinics like urgent care centers and retail health clinics. At a hospital emergency room, you’ll owe a $50 copay.	42-43, 104-105
✓ **Take advantage of the preferred vendor benefit**	Some services, supplies and medical equipment have a preferred vendor benefit. Medicare suppliers, when available, are the preferred vendors. If no Medicare supplier is available, there may be a UniCare preferred vendor you can use. In this handbook, the **checkmark** ✓ identifies services with a preferred vendor benefit.	23
Other ways to keep your costs down		**See pages**
Get $100 toward your fitness costs	We’ll reimburse you for up to $100 of your costs toward a fitness activity.	46
Keep an eye on your bills	Don’t pay a bill before you’ve gotten payment notices (EOBs) from both Medicare and UniCare. If you’re not sure whether you owe a payment, give us a call.	18

Chapter 2: About costs and billing

What member costs are (out-of-pocket costs)

Member costs are the costs that you pay toward your medical bills. Member costs may also be called **out-of-pocket costs**, **cost sharing**, or **member share**.

Medicare Extension members have two kinds of member costs. These costs are separate and unrelated; they apply in different situations and are for different services.

Types of member costs		See pages
Copays	A fixed amount you pay when you get certain healthcare services, like seeing your doctor for a sprained ankle.	20
Coinsurance	For some services, the Plan pays 80% and you pay the other 20%. The 20% that you owe is called coinsurance.	20

How member costs work

Medicare pays its portion of your claims first. Then, because you are in UniCare's Medicare Extension plan, the remainder of the claim balance is sent to UniCare.

When UniCare gets the bill, 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 any coinsurance that applies. We'll send you an *Explanation of Benefits* (EOB), which is a statement that shows how the claim was paid and what member costs you owe, if any.

After getting payment from UniCare, your provider will bill you for any member costs – copays and/or coinsurance – that UniCare subtracted from its payment. (If you had any services from that provider that weren't covered by your Plan, the provider's bill may include those charges too.)

UniCare processes claims as they come in. This means that your claims may not get paid in the same order in which you got the medical services.

Limits on your out-of-pocket costs

The Plan limits some of the member costs you have to pay each year toward covered services. These limits are called **out-of-pocket (OOP) maximums**. Once you reach an out-of-pocket maximum, the Plan pays 100% of the allowed amounts for covered services for the rest of the calendar year. (To learn more about allowed amounts, see "About allowed amounts and Medicare-approved amounts" on page 21).

Out-of-pocket (OOP) maximums in this plan

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

- ❑ The **coinsurance limit** caps the amount of coinsurance you owe for medical services.
- ❑ The out-of-pocket maximum on **in-network behavioral health** limits your member costs when you get behavioral health services from in-network providers.
- ❑ The out-of-pocket maximum on **out-of-network behavioral health** limits your member costs when you get behavioral health services from out-of-network providers.

Table 2. How much are the out-of-pocket (OOP) maximums?

How much are the OOP maximums?	
Coinsurance limit	$500
OOP maximum on in-network behavioral health	$1,000
OOP maximum on out-of-network behavioral health	$3,000

Costs that don't count toward your OOP maximums

☞ **Important!** The following costs don't apply to any out-of-pocket maximums:

- ❑ Prescription drug costs
- ❑ Premiums
- ❑ Balance bills (charges over the Plan's allowed amounts)
- ❑ Costs for health care that the Plan doesn't cover

About copays

A **copay** is a payment you owe at the time you get a service. For example, you pay a copay when you see your doctor for a sore throat, or when you go to the emergency room. You have copays for some medical services and for some behavioral health services.

Services that have copays include:

- ❑ Doctor visits (page 40) – Copays apply both in person and through virtual care (telehealth)
- ❑ Urgent care centers and retail health clinic visits (page 42)
- ❑ Routine eye exams (page 44)
- ❑ Emergency room visits (page 42)
- ❑ Behavioral health outpatient services (Chapter 9)

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%. As is true of all member costs, coinsurance is applied to any balance that remains after Medicare processes your claim.

How Medicare and Medicare Extension work together

You must be enrolled in Medicare Part A and Part B to be eligible for the Medicare Extension plan. If you let your Medicare coverage lapse, you will no longer be eligible for benefits under the Medicare Extension plan.

Do not enroll in a non-GIC Medicare Part D product. This plan includes Medicare Part D coverage. If you enroll in another Part D product, the Centers for Medicare and Medicaid Services (CMS) will disenroll you from your GIC coverage. This means that you will lose your GIC health, behavioral health, and prescription drug benefits.

What the Medicare Extension plan covers

Medicare Extension covers all or part of any costs that Medicare does not pay for covered services. For example, if Medicare pays 80% of a claim, the Plan will pay some or all of the remaining 20%. The Plan also covers the Medicare Part A inpatient deductible, the Part B deductible, and Part B coinsurance.

Keep in mind... Medicare Part A provides benefits for hospital services, and Part B provides benefits for physician and other healthcare provider services.

Medicare Extension provides coverage for some services that Medicare doesn't cover, such as immunizations and hearing aids.

There are also some services that Medicare covers but Medicare Extension does not. See Chapter 10 (pages 90-102) to find out which services are not covered or have limited coverage.

How benefits are determined between Medicare and Medicare Extension

When you submit a claim, UniCare determines your benefits as follows:

1. The claim is eligible for payment only if it is for a covered service under Medicare and/or the Medicare Extension plan.
2. The maximum amount that may be paid is the Medicare-approved amount or, if the service isn't covered by Medicare, UniCare's allowed amount (see the next topic).
3. UniCare subtracts any benefits that Medicare has paid from the original amount of the claim.
4. Medicare Extension benefits are applied to any remaining claim balance.

About allowed amounts and Medicare-approved amounts

Medicare sets an allowed cost – the **Medicare-approved amount** – for each service that it covers, and makes payments based on that amount. So, for example, if Medicare covers 80% of a service, it will pay up to 80% of the Medicare-approved amount for that service.

UniCare sets an **allowed amount** for each service that it covers. The allowed amount is the maximum amount that UniCare pays for a covered service. UniCare uses the Medicare-approved amount as its allowed amount for services covered by Medicare. For services not covered by Medicare, the allowed amount is the amount UniCare determines to be within the range of payments most often made to similar providers for the same service or supply.

About balance billing

The allowed amount for a given service may not be the same as what a provider actually billed for that service. When a provider asks you to pay for charges 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 coinsurance limit (page 19).

When you get care in Massachusetts

- **Medical providers** – Medical providers in Massachusetts are not allowed to balance bill you for charges over the allowed amount (Massachusetts General Law, Chapter 32A: Section 20). If a Massachusetts medical provider balance bills you, contact UniCare Member Services at 800-442-9300 for help.

- **Behavioral health providers** – Behavioral health providers who are in the Carelon Behavioral Health network won't balance bill you. However, out-of-network behavioral health providers in Massachusetts may do so. Since the Plan doesn't cover balance bills, payment is your responsibility. If you need help finding an in-network provider, contact UniCare Member Services at 800-442-9300.

  If you have a continuing relationship with an out-of-network behavioral health provider, you may make other payment arrangements with that provider in addition to the payments made by UniCare.

If you get care outside of Massachusetts

Outside of Massachusetts, providers may balance bill you for the difference between the Plan's allowed amount and the provider's charges. Since the Plan doesn't cover balance bills, payment is your responsibility.

To reduce your risk of being balance billed, we recommend always using Medicare participating providers when you need medical care. See the next topic to learn how a provider's payment arrangement with Medicare can affect your costs.

For behavioral health services, you won't be balance billed if you use providers in the Carelon Behavioral Health network. See Part 3 (pages 73-88) for information about your behavioral health benefits.

How the providers you use can affect your costs

Providers, such as doctors and medical equipment suppliers, can have several different payment arrangements with Medicare. These arrangements determine how much Medicare pays the providers and what costs you will have to pay yourself.

- **Medicare enrolled providers** agree to do business with Medicare and accept Medicare payment. Medicare will only pay for services from enrolled providers. Enrolled providers have two different payment arrangements:
  1. **Medicare participating providers (those who "accept Medicare assignment")** are enrolled providers who accept Medicare's payment as payment in full for covered services.
  2. **Medicare non-participating providers** are enrolled providers who have not agreed to accept Medicare assignment. They may charge more than the Medicare-approved amount (within certain limits), and you are responsible for the additional cost.
- **Private contract providers** don't do any business with Medicare at all. Medicare won't pay for services from these providers, even if the service would otherwise be covered. These providers are required to have you sign a private contract (called an **Advance Beneficiary Notice of Noncoverage**, or **ABN**) to confirm that you will pay for the services yourself.

Important! If you go to a private contract provider for a service that Medicare would otherwise cover, the plan's allowed amount is only 20% of what Medicare would have paid to an enrolled provider. Your benefit is then applied to that allowed amount. You must pay the rest of the cost yourself.

For more information – See your *Medicare & You* handbook (available at www.medicare.gov) and other Medicare publications for additional information about how Medicare pays providers.

Table 3 illustrates how your benefits work for the three types of providers.

Table 3. How Medicare-provider arrangements affect benefits

Type of provider	Claim amount	Allowed amount	Medicare pays	UniCare pays	You owe
Participating providers (those who accept Medicare assignment)	$150	$100	$80	$20	$0
Non-participating providers	$150	$100	$80	$20	$50[1]
Private contract providers	$150	$100	$0	$20[2]	$130[3]

1. The amount of the claim left over after Medicare and UniCare have paid
2. UniCare pays only what it would have paid if you had used a participating provider
3. The amount of the claim that neither Medicare nor UniCare paid

When to use preferred vendors

For certain services and supplies, you get the highest benefit when you use a preferred vendor. **Preferred vendors** are Medicare suppliers, UniCare-contracted vendors, or both who provide one or more of the following services and supplies:

- ❑ Durable medical equipment (DME)
- ❑ Home health care
- ❑ Home infusion therapy (including enteral therapy)
- ❑ Medical/diabetic supplies
- ❑ Orthotics, prostheses and prosthetic devices

Medicare suppliers, when available, are the preferred vendors for these services and supplies – that is, you'll get the preferred vendor benefit when you use a Medicare supplier.

Find Medicare suppliers at medicare.gov

If there aren't any Medicare suppliers for the service or supply you need, there may be a UniCare preferred vendor you can use to get the best benefit.

Preferred vendors are covered at 100% of the allowed amount. If you don't use a preferred vendor, the Plan covers 80% of the allowed amount and you owe the remaining 20% coinsurance. This is true even if you are using a non-preferred vendor because the item or service isn't available from a preferred vendor. If you live outside of Massachusetts, preferred vendors won't balance bill you for charges over the allowed amount, but other vendors may do so.

 Find a list of UniCare preferred vendors at unicaremass.com

 In this handbook, the checkmark lets you know when a service has 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.

PART 2:

YOUR MEDICAL BENEFITS

Description of coverage for medical services

For questions about any of the information in Part 2 of this handbook, please call UniCare Member Services at 800-442-9300.

Administered by

UniCare℠

Chapter 3: Preapproval reviews for medical services

What are preapproval reviews?

Preapproval (also called **preauthorization**) confirms that a service you're getting is medically necessary and will be eligible for benefits. By getting a service preapproved, you can make sure that the service is covered under the Plan.

Benefits offered by Medicare and UniCare apply to services that are medically necessary. As the primary insurer, Medicare determines medically necessity for the services it covers. In most cases, UniCare does not separately review services that Medicare covers.

In some limited circumstances, such as when Medicare benefits have been exhausted or for services that Medicare doesn't cover, UniCare may review services for eligibility.

In most cases, your doctor will provide UniCare with the information necessary to review a service. If you need help with a preapproval, UniCare Member Services can contact your provider to make the arrangements.

Examples of medical services that may require review

UniCare may review a medical service if your Medicare benefits for the service have been exhausted or if it's a service that Medicare doesn't cover. Types of medical services that may need to be reviewed include:

- ❑ Inpatient admissions
- ❑ Durable medical equipment (DME)
- ❑ Enteral therapy
- ❑ Home health care
- ❑ Surgeries such as organ transplants and gender reassignment

Preapprovals for behavioral health services – See pages 75-77 for information about preapprovals for behavioral health services.

Chapter 4: Summary of costs for medical services

Table 4. Summary of covered medical services

Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 21).

Service	Member costs	See page
Ambulances	No member costs	31
Behavioral health services (mental health and substance use disorder)	See Part 3 (pages 73-88) for benefits information.	73
Bereavement counseling	20% coinsurance (limited to $1,500 for a family in a calendar year)	50
Cardiac rehab programs	No member costs	33
Chemotherapy	No member costs	33
Chiropractic care	No member costs (limited to 20 visits in a calendar year)	34
✓ **Diabetic supplies**	▪ **Preferred vendors:** No member costs ▪ **Non-preferred vendors:** 20% coinsurance	38
Dialysis	No member costs	39
Doctor visits (in person or through virtual care)	$10 copay	40
Doctors – other services		40
▪ At an emergency room	No member costs	
▪ Inpatient hospital care	No member costs	
▪ Outpatient hospital care	$10 copay	
Durable medical equipment (DME)	▪ **Preferred vendors:** No member costs ▪ **Non-preferred vendors:** 20% coinsurance	40
Early intervention programs	No member costs (limited to $5,200 for each child in a calendar year, with a lifetime limit of $15,600 for each child)	42

Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 21).

Service	Member costs	See page
Emergency room visits	$50 copay	42
Eye exams (routine)	$10 copay (limited to one exam every 24 months)	44
Eyeglasses and contact lenses	No member costs (limited to first set within six months of the eye injury or cataract surgery)	45
Family planning services	No member costs	45
Fitness reimbursement	Reimbursed up to $100 per member in a calendar year	46
Hearing aids		48
▪ 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	$10 copay	48
✓ **Home health care**	▪ **Preferred vendors:** No member costs ▪ **Non-preferred vendors:** 20% coinsurance	49
✓ **Home infusion therapy**	▪ **Preferred vendors:** No member costs ▪ **Non-preferred vendors:** 20% coinsurance	50
Hospice care	No member costs	50
Immunizations (vaccines)	No member costs (you may have costs for the office visit)	52
Inpatient medical care		54
▪ At a hospital or rehab facility (semi-private room)	No member costs	
▪ At a hospital or rehab facility (medically necessary private room)	The dollar difference between the semi-private room rate and the private room rate	
Lab and radiology services (X-rays)		56
▪ Emergency room	No member costs	
▪ Inpatient hospital	No member costs	
▪ Outpatient hospital	No member costs	
▪ Non-hospital-owned facility	No member costs	

Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 21).

Service	Member costs	See page
Medical services, if not listed elsewhere	20% coinsurance	57
Occupational therapy	▪ **If Medicare pays:** No member costs ▪ **If Medicare does *not* pay:** 20% coinsurance	58
Outpatient hospital services, if not listed elsewhere	No member costs	59
✓ **Oxygen**	▪ **Preferred vendors:** No member costs ▪ **Non-preferred vendors:** 20% coinsurance	59
Personal Emergency Response Systems		60
▪ Installation	20% coinsurance (limited to $50 in a calendar year)	
▪ Rental	No member costs (limited to $40 a month)	
Physical therapy	▪ **If Medicare pays:** No member costs ▪ **If Medicare does *not* pay:** 20% coinsurance	60
Prescription drugs	Benefits are administered by SilverScript. See Part 5 of this handbook, or call SilverScript at 877-876-7214 (toll free) for more information.	137
Preventive care *See Table 7 on page 68.*	No member costs	61
Prosthetics and orthotics		62
▪ Breast prosthetics	No member costs	
▪ Other prosthetics and orthotics	▪ **If Medicare pays:** No member costs ▪ **If Medicare does *not* pay:** 20% coinsurance	
Radiation therapy	No member costs	63
Radiology and imaging		56
▪ Emergency room	No member costs	
▪ Inpatient hospital	No member costs	
▪ Outpatient hospital	No member costs	
Retail health clinic visits	$10 copay	42

Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 21).

Service	Member costs	See page
Skilled nursing and long-term care facilities	▪ **Days paid by Medicare:** No member costs until Plan benefit limit is reached ▪ **Days *not* paid by Medicare:** 20% coinsurance until Plan benefit limit is reached Plan benefit limit is $13,400 each calendar year	54
Speech therapy	No member costs	64
Surgery		64
▪ In Massachusetts	No member costs	
▪ Outside Massachusetts	▪ **Medicare participating:** No member costs ▪ **Medicare non-participating:** 20% of the difference between the Plan's allowed amount and the provider's charge	
Tobacco cessation counseling	No member costs (limited to 300 minutes in a calendar year)	65
Transplants		66
▪ At a Medicare-certified transplant facility	No member costs	
▪ At other hospitals	20% coinsurance	
Urgent care center visits	$10 copay	42

Chapter 5: Covered medical services

Allergy shots

Allergy shots are covered. Claims for allergy shots may separately itemize the shot itself, the allergy serum (in the shot), and the office visit (when the shots were given).

	Member costs
Shot (injection)	No member costs
Allergy serum	20% coinsurance
Office visit	$10 copay

Ambulances and transportation

Ambulance transportation is covered in medical emergencies. Some examples of emergencies are stroke, heart attack, difficulty breathing, and severe pain. Covered emergency medical transportation may be by ground, air, or water ambulance, depending on the emergency situation.

	Member costs
Ambulance transportation	No member costs

Restrictions:

- The following restrictions apply to emergency ambulance transportation:
  - Based on the severity of your condition, no other form of transportation can safely transport you to the nearest facility.
  - Air or water ambulance is covered only when your medical condition is such that your health would be endangered by the time needed for ground transportation.
  - Emergency inter-facility transportation to the nearest appropriate facility may be necessary when your current facility is unable to treat your condition and the treatment is considered a medical emergency.
- All ambulance transportation must be medically necessary and must take you to the nearest appropriate hospital or facility.
- There is no coverage for transportation that is primarily for the convenience of the individual, individual's family, or physician.
- Transfers to a hospital that you prefer (e.g., to be closer to home) are not covered.
- Transportation in chair cars or vans is not covered.

Anesthesia

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

	Member costs
Anesthesia and its administration	No member costs

✕ Restrictions:

- Other charges associated with ECT are covered under your behavioral health benefit. See Part 3 of this handbook (pages 73-88) for benefits information.
- There is no coverage for anesthesia used for a non-covered procedure.

Autism spectrum disorders

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

Medical services for autism spectrum disorders are covered like any other physical condition. Coverage is subject to all pertinent provisions of the Plan, including use of participating providers, preapproval reviews, and provider payment methods. Medical services needed for diagnosis and treatment (such as occupational therapy) are covered as a medical benefit. Behavioral health services are covered as a behavioral health benefit (page 80).

Behavioral health services

Treatments for mental health and substance use disorder conditions are called **behavioral health services**. See Part 3 (pages 73-88) for benefits information.

Cardiac rehabilitation (rehab) programs

Cardiac rehab programs are professionally-supervised, multi-disciplinary programs to help people recover from cardiac events like heart attacks, heart surgery, and coronary procedures such as stenting and angioplasty. Covered cardiac rehab includes education and counseling services to help increase physical fitness, reduce cardiac symptoms, improve health, and reduce the risk of future heart problems.

	Member costs
Cardiac rehab programs	No member costs

A cardiac rehab program must:

- ❑ Be ordered by a physician
- ❑ Be operated by a licensed clinic or hospital
- ❑ Teach and monitor risk reduction, lifestyle adjustments, therapeutic exercise, proper diet, use of proper prescription drugs, self-assessment, and self-help skills
- ❑ Meet the generally accepted standards of cardiac rehab

This benefit covers the *active* rehabilitation phase of the program, which is usually three consecutive months.

✕ Restrictions:

- You must start the program within six months after your cardiac event.
- You can participate in only one cardiac rehab program after a cardiac event.
- There is no coverage for the *maintenance* phase of a cardiac rehab program. Coverage is for the *active* phase only.
- You are not covered for a cardiac rehab program if you have not had a cardiac event.

Chemotherapy

Chemotherapy is a covered service. The drugs used in chemotherapy may be administered by injection, infusion, or orally.

	Member costs
Outpatient	No member costs
Inpatient	Covered under the benefit for hospital admissions (page 54)

Chiropractic care

The Plan covers up to 20 chiropractic visits each calendar year, when they are used on a short-term basis to treat neuromuscular and/or musculoskeletal conditions and when the potential for functional gain exists.

	Member costs
Chiropractic care	No member costs (limited to 20 visits in a calendar 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.

Circumcision

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

	Member costs
Circumcision	No member costs

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.

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:

- ❑ The clinical trial is to study potential treatments for cancer.
- ❑ 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
- ❑ 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.
- ❑ 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.
- ❑ The member meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.
- ❑ The member has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.

- ❑ 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.
- ❑ The clinical trial does not unjustifiably duplicate existing studies.
- ❑ 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, including donor 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-healthcare 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 34) – The following services are covered specifically for the treatment of cleft lip or palate, if not otherwise covered by a dental plan:
  - Dental services
  - Orthodontic treatment
  - Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic or prosthetic treatment

✕ Restrictions:

- ■ There is no coverage for any services provided in a dentist's office.
- ■ Facility fees, anesthesia and other charges related to non-covered dental services are not covered.
- ■ Dentures, dental prosthetics and related surgery are not covered.
- ■ Braces and other orthodontic treatment, including treatment done to prepare for surgery, are not covered.
- ■ Treatment of temporomandibular joint (TMJ) disorder is limited to the initial diagnostic examination, initial testing and medically necessary surgery.

Diabetes care

Coverage for diabetes care applies to services prescribed by a doctor for insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes. Covered services include outpatient self-management training and patient management, as well as nutritional therapy.

Patient management refers to outpatient education and training for a person with diabetes, given by a person or entity with experience in treating diabetes. It is done in consultation with your physician, who must certify that the services are part of a comprehensive care plan related to your condition. The services must also be needed to ensure therapy or compliance, or to give you the skills and knowledge necessary to successfully manage your condition.

Diabetes self-management training and patient management, including nutritional therapy, may be conducted individually or in a group. It must be provided by an education program recognized by the American Diabetes Association or by a Certified Diabetes Educator® (CDE®). Coverage includes all educational materials for the program.

Benefits are available in the following situations:

- ❑ You are initially diagnosed with diabetes
- ❑ Your symptoms or condition change significantly, requiring changes in self-management
- ❑ You need refresher patient management
- ❑ You are prescribed new medications or treatment

Screenings for Type 2 and gestational diabetes are covered as preventive services (Chapter 6).

Diabetic supplies and equipment

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

	Member costs
✓ **Diabetic supplies**	▪ **Preferred vendors:** No member costs ▪ **Non-preferred vendors:** 20% coinsurance

The following supplies and equipment 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) are covered under your prescription drug plan. In addition, if you buy diabetic supplies at a pharmacy, the supplies may also be covered under your prescription drug plan. See Part 5 of this handbook (pages 137-144).

✕ 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.

✓ Use Medicare suppliers or UniCare preferred vendors (page 23) – Use a UniCare preferred vendor if there is no Medicare supplier available.

Look for Medicare suppliers at medicare.gov. Find a list of UniCare preferred vendors at unicaremass.com.

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.

	Member costs
Dialysis	No member costs

✕ Restrictions:

- There is no coverage for transportation to dialysis appointments.
- There is no coverage for hemodialysis to treat a behavioral health condition.

Doctor and other medical provider services

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

	Member costs
Provider visits – In person or through virtual care (telehealth)	$10 copay
Emergency room care	No member costs
Inpatient hospital care	No member costs
Outpatient hospital care	$10 copay

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

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

✕ Restrictions:

- 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.

Durable medical equipment (DME)

Durable medical equipment (DME) is equipment and supplies – such as wheelchairs, crutches, oxygen and respiratory equipment – that is ordered by a doctor for daily or extended use. The Plan covers medically necessary DME if the item meets all of the following requirements:

- ❑ Designed primarily for therapeutic purposes or to improve physical function
- ❑ Able to withstand repeated use
- ❑ Provided in connection with the treatment of disease, injury or pregnancy
- ❑ Ordered by a physician
- ❑ Provided by a DME supplier

	Member costs
Durable medical equipment (DME)	▪ **Preferred vendors:** No member costs ▪ **Non-preferred vendors:** 20% coinsurance

The Plan covers rental or purchase depending on the item, its use, and the expected total cost.

✕ Restrictions:

- The 20% coinsurance doesn't count toward the coinsurance limit.
- 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, non-hospital beds, orthopedic mattresses, shower chairs, telephones, televisions, thermal therapy devices, whirlpools).
- Compression stockings are covered up to a limit of four pairs within a 365-day period.
- The Plan will not cover any rental charges that exceed the purchase price of an item.

✓ Use Medicare suppliers or UniCare preferred vendors (page 23) – Use a UniCare preferred vendor if there is no Medicare supplier available.

Look for Medicare suppliers at medicare.gov. Find a list of UniCare preferred vendors at unicaremass.com.

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 healthcare providers working within an early intervention services program approved by the Massachusetts Department of Public Health, or under a similar law in other states.

	Member costs
Early intervention programs	No member costs (limited to $5,200 for each child in a calendar year, with a lifetime limit of $15,600 for each child)

Emergency care / urgent care

If you are facing a medical or behavioral health 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.

	Member costs
Hospital emergency room	$50 copay (waived if admitted to the hospital)
Urgent care center visits	$10 copay
Retail health clinic visits	$10 copay
Medical practice visits	$10 copay

An **emergency** is an illness or medical condition, whether physical or behavioral, characterized by symptoms of sufficient severity that the absence of prompt medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- ❑ Serious jeopardy to physical and/or mental health
- ❑ Serious impairment to bodily functions
- ❑ Serious dysfunction of any bodily organ or part
- ❑ In the case of pregnancy, a threat to the safety of a member or her unborn child

Some examples of illnesses or medical conditions requiring emergency care are severe pain, a broken leg, loss of consciousness, vomiting blood, chest pain, difficulty breathing, or any medical condition that is quickly worsening.

Urgent care refers to services you get when your health is not in serious danger but you need medical attention right away. Some conditions you might seek urgent care for are listed in Table 5.

Table 5. Example conditions for urgent care

When you might want to get urgent care	
▪ Cough	▪ Minor allergic reactions
▪ Sore throat	▪ Bumps, cuts, and scrapes
▪ Minor fever, cold or flu	▪ Minor burn or rash
▪ Nausea, vomiting, or diarrhea	▪ Burning with urination
▪ Back pain	▪ Eye swelling, pain, redness or irritation
▪ Muscle strain or sprain	▪ Animal bites
▪ Ear or sinus pain	▪ Stitches
▪ Mild headache	▪ X-rays or lab tests

For urgent care, your member costs are lower if you go to a walk-in clinic instead of a hospital emergency department. **Walk-in clinics** are sites that offer medical care on a walk-in basis, so no appointment is needed. Although walk-in clinics have a variety of different names, they fall into four general categories. These four categories differ based on the services they offer and how they bill for their services.

- ❑ **Medical practices** – Some doctors' offices offer services to walk-in patients. They offer the services you'd expect to get at a primary care practice.
- ❑ **Retail health clinics** are located in retail stores or pharmacies. They offer basic services like vaccinations and treatment for colds or mild sinus infections.
- ❑ **Urgent care centers** are independent, freestanding locations that treat conditions that should be handled quickly but that aren't life-threatening. They often do X-rays, lab tests and stitches.
- ❑ **Hospitals** – Some hospitals have walk-in clinics within or associated with their emergency departments.

☞ **Important!** A facility's name isn't always a guide to how it bills or what your member costs will be. For example, a walk-in clinic that calls itself an urgent care center may bill as a hospital emergency room or a medical practice, instead of as an urgent care center. Before you use a walk-in clinic, you may want to ask how your visit will be billed. As the benefits chart shows, how your visit is billed determines how much you owe.

✕ Restrictions:

- ■ Charges for non-emergency services received at an emergency room are covered under the appropriate plan benefit. For example, a non-emergency CT scan would be covered under the radiology benefit (described on page 56) rather than the emergency room benefit.

Enteral therapy

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

	Member costs
✓ **Enteral therapy**	▪ **Preferred vendors:** No member costs ▪ **Non-preferred vendors:** 20% coinsurance

✕ Restrictions:

- The 20% coinsurance doesn't count toward the coinsurance limit.

✓ **Use UniCare preferred vendors** (page 23) – Enteral therapy from a UniCare preferred vendor is covered at 100% of the allowed amount. From non-preferred vendors, enteral therapy is covered at 80%, so you owe 20% coinsurance.

Find a list of UniCare preferred vendors at unicaremass.com.

Eye care

The Plan covers routine eye exams once every 24 months. Other eye care services are covered if you have eye problems due to a medical condition.

	Member costs
Routine eye exams Refraction/glaucoma testing	$10 copay (limited to one exam every 24 months)
Eye care office visits When medically necessary	$10 copay
Vision therapy	$10 copay

Routine eye exams can be performed by an ophthalmologist or optometrist. 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).

Eyeglasses and contact lenses

Generally, the Plan does not cover eyeglasses or contact lenses. However, a set of eyeglasses or contact lenses is covered after an eye injury or cataract surgery. You must purchase the eyeglasses or contact lenses within six months of the surgery. Standard frames and lenses, including bifocal and trifocal lenses, are covered.

	Member costs
Eyeglasses and contact lenses	No member costs (limited to the first set within six months of eye injury or cataract surgery)

Restrictions:

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

Important! Medicare only pays for contact lenses or eyeglasses from Medicare suppliers, no matter who submits the claim (you or the supplier). If you don't use a Medicare supplier, the Plan covers only 20% of the allowed amount. You must pay the rest of the cost yourself.

Look for Medicare suppliers at medicare.gov.

Family planning

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

	Member costs
Family planning services	No member costs

Covered services include:

- ❑ Fitting for a diaphragm or cervical cap
- ❑ Insertion, re-insertion, or removal of an IUD or Levonorgestrel (Norplant)
- ❑ Injection of progesterone (Depo-Provera)
- ❑ Office visits, including evaluations, consultations, and follow-up care
- ❑ Voluntary female sterilization (tubal ligation)
- ❑ Voluntary male sterilization (vasectomy)
- ❑ Voluntary termination of pregnancy (abortion)

FDA-approved contraceptive drugs and devices are available through your prescription drug plan (see Part 5 of this handbook).

Fitness reimbursement

You can get reimbursed for up to $100 per member on costs associated with participation in a fitness activity. The fitness reimbursement is paid to the plan enrollee upon proof of payment.

	Member costs
Fitness reimbursement	Costs are reimbursed up to $100 per member each calendar year

To receive the fitness reimbursement, you must attest to participating in physical activity an average of four or more times per month, and you must submit proof of payment toward an eligible activity. Eligible costs include:

- ❑ Gyms, health clubs, fitness centers, Boys & Girls Clubs of America, dance studios, martial arts centers, etc.
- ❑ Classes and programs such as yoga, Pilates, spin, Zumba, and gymnastics (either in-person or online)
- ❑ Organizations and leagues designed for fitness activities (e.g., sports teams, hiking, bowling, etc.)
- ❑ Personal trainers (either in-person or online)

Use the *Fitness Reimbursement* form to submit your request for this reimbursement.

Download the *Fitness Reimbursement* form from unicaremass.com. A copy of the form also appears in Appendix B.

✕ Restrictions:

- Although any family members may have fitness memberships, the total reimbursement is paid to the plan enrollee only.
- Ineligible costs include beach or country club memberships or dues; fees for one-day events; annual or day passes (such as for skiing); spas or spa services; personal or home fitness equipment.

Foot care (routine)

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

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

	Member costs
Routine foot care	$10 copay

✕ Restrictions:

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

Gender affirmation (reassignment) services

Services for treatment associated with gender affirmation (reassignment) are covered like any other physical condition. Coverage is subject to all pertinent provisions of the Plan including medical necessity, use of participating providers, preapproval reviews, benefit limitations, and provider payment methods.

Medical services needed for diagnosis and treatment are covered under your medical benefit. Behavioral health services are covered as a behavioral health benefit (Part 3 of this handbook).

Covered services include:

- ❑ Breast/chest ("top") and genital/reproductive organ ("bottom") surgeries
- ❑ Electrolysis (hair removal) when part of surgical preparation
- ❑ Facial reconstruction procedures, such as tracheal shaving
- ❑ Surgical repair and fertility preservation coverage, including up to 12 months of storage

For a list of specific covered services, contact UniCare Member Services at 800-442-9300.

✕ Restrictions:

- Fertility storage (storage of sperm or eggs) is limited to a maximum of 12 months.
- Surgical reversal of original procedure is not covered.

Gynecology exams

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

	Member costs
Annual exam, with Pap smear	No member costs
Office visits	$10 copay

Hearing aids

Hearing aids are covered to correct a member's hearing loss that has been documented through testing.

	Member costs
Age 21 and under	No member costs (limited to $2,000 for each impaired ear every 24 months)
Age 22 and over	No member costs (limited to $1,700 for each impaired ear every 24 months)

✕ Restrictions:

- Over-the-counter (OTC) hearing aids are not covered.
- Ear molds are not covered, except when needed for hearing aids for members age 21 and under.
- Hearing aid batteries are not covered.
- Replacement hearing aids are covered only if you have not reached the benefit limit, and if:
  - You need a new hearing aid prescription because your medical condition has changed, or
  - The hearing aid no longer works properly and cannot be repaired

Hearing exams

Expenses for hearing exams for the diagnosis of speech, hearing and language disorders are covered. These exams are typically provided by a physician or a licensed audiologist. The exam must be administered in a hospital, clinic or private office.

	Member costs
Office visit	$10 copay
Hearing screenings for newborns	No member costs

✕ Restrictions:

- Services provided through schools are not covered.

Home health care

Home health care includes any skilled services and supplies provided by a Medicare-certified home health care agency or **visiting nurse association (VNA)** on a part-time, intermittent, or visiting basis.

Benefits for home health care are available when:

- ❑ Your doctor prescribes a **plan of care** – that is, a written order outlining services to be provided in the home – that will be administered by a home health care agency or VNA. The home health agency or VNA must meet any applicable licensing requirements.
- ❑ The services and supplies are provided in a non-institutional setting while you are housebound as a result of injury, disease or pregnancy.

The plan of care is subject to review and approval by the Plan.

	Member costs
✓ **Home health care**	▪ **Preferred vendors:** No member costs ▪ **Non-preferred vendors:** 20% coinsurance

The following services are covered if they are provided (or supervised) by a healthcare 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 private duty nursing.
- There is no coverage for services received from someone who is in your immediate family. Your immediate family consists of you, your spouse and your children, as well as the brothers, sisters and parents of both you and your spouse. This includes any service that a provider may perform on himself or herself.
- There is no coverage for services received from anyone who shares your legal residence.

✓ **Use UniCare preferred vendors** (page 23) – Home health services from a UniCare preferred vendor are covered at 100% of the allowed amount. From non-preferred vendors, home health services are covered at 80%, so you owe 20% coinsurance.

Find a list of UniCare preferred vendors at unicaremass.com.

Home infusion therapy

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

	Member costs
✓ **Home infusion therapy**	▪ **Preferred vendors:** No member costs ▪ **Non-preferred vendors:** 20% coinsurance

✕ Restrictions:

- The 20% coinsurance doesn't count toward your coinsurance limit.
- You must get subcutaneous and intramuscular drugs through your prescription drug plan.

✓ **Use UniCare preferred vendors** (page 23) – Home infusion therapy from a UniCare preferred vendor is covered at 100% of the allowed amount. From non-preferred vendors, home infusion therapy is covered at 80%, so you owe 20% coinsurance.

Find a list of UniCare preferred vendors at unicaremass.com.

Hospice and end-of-life care

Hospice provides multidisciplinary care to address the physical, social, emotional, and spiritual needs of persons likely to live six months 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 six 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 six months to live, but you have symptoms like severe pain or difficulty breathing, the Plan covers **palliative care** (page 59). Palliative care is focused on relieving pain or other symptoms of illness and improving the quality of life for patients and their families.

	Member costs
Hospice care	No member costs
Bereavement counseling	20% coinsurance (limited to $1,500 for a family in a calendar year)

The Plan covers the following hospice services:

- ❑ Part-time, intermittent nursing care or home health aide services provided by or supervised by a registered nurse
- ❑ Physical, respiratory, occupational and speech therapy from an appropriately licensed or certified therapist
- ❑ Medical social services
- ❑ Medical supplies and medical appliances
- ❑ Drugs and medications prescribed by a physician and charged by the hospice
- ❑ Laboratory services
- ❑ Physician services
- ❑ Transportation to the place where you will be receiving covered hospice services
- ❑ 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:

- The 20% coinsurance for bereavement counseling doesn't count toward the coinsurance limit.
- 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 (pages 73-88).
- 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.

Immunizations (vaccines)

Immunizations (vaccines) recommended by the U.S. Preventive Services Task Force are covered at 100%, according to the preventive care schedule (Chapter 6).

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

Restrictions:

- Unless you are pregnant, there is no coverage for blood tests (titers) to determine if you need an immunization. See **Immunization titers** on page 96.

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 member demonstrates infertility according to one of the following definitions:

- ❑ The inability of opposite-sex partners under the age of 35 to achieve conception after at least 12 months of unprotected intercourse.
- ❑ The inability of opposite-sex partners to achieve conception after six months of unprotected intercourse when the female partner (partner with a uterus and ovaries) trying to conceive is age 35 or older.
- ❑ The inability of a member with a uterus and ovaries, with or without an opposite sex partner, to achieve conception after at least six trials of medically supervised artificial insemination.
- ❑ The inability of a member with a uterus and ovaries, with or without an opposite-sex partner, to achieve conception after at least three trials of medically supervised artificial insemination over a six-month period of time when the member with a uterus and ovaries who is trying to conceive is age 35 or older.

If a pregnancy ends in miscarriage, the time spent trying to conceive (prior to the pregnancy) is counted as part of the window as defined above.

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)
- ❑ Preimplantation genetic testing (PGT)
- ❑ 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).
- 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.
- Infertility services provided as part of gender affirmation (reassignment) treatment (page 47) do not need to meet the definition of infertility described in this section.
- Storage fees for storing or banking sperm, eggs, and/or inseminated eggs are covered only when provided as part of gender affirmation treatment, and are limited to a maximum of 12 months in storage.
- The Plan does not pay people to be surrogates (gestational carriers) for UniCare 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.

Inpatient medical care (hospital admissions)

The Plan covers hospital services when you are admitted to an inpatient facility. Facilities that provide inpatient hospital care include acute care hospitals, rehabilitation facilities, long-term care facilities, and skilled nursing facilities. Coverage for inpatient hospital services includes all medically necessary services and supplies.

The benefit for hospital services depends on the type of facility you go to and the type of care you get:

- **Acute care hospitals** are medical centers and community hospitals that provide treatment for a severe illness, for conditions caused by disease or trauma, and for recovery from surgery. These hospitals deliver intensive, 24-hour medical and nursing care.
- **Rehabilitation (rehab) facilities** are specialized hospitals that provide rehab services to restore basic functioning (such as walking or sitting upright) that was lost due to illness or injury. Patients in these facilities have a good potential for recovery and are able to participate in a rehab program that includes therapy services for three to five hours a day.
- **Long-term care facilities** are specialized hospitals that treat patients who need further care for complex medical conditions but that no longer require the services of a traditional hospital. These patients' needs are mostly medical and their ability to participate in rehab is limited.
- **Skilled nursing facilities** provide lower intensity rehab and medical services. Patients in these facilities have continuing medical needs that require skilled nursing care, but do not need daily physician care. Some of these patients may or may not require rehab, while others may need long-term custodial care (see "Restrictions," later in this section).

At a hospital or rehab facility	Member costs
Inpatient services (semi-private room)	No member costs
Inpatient services (medically necessary private room)	The dollar difference between the semi-private room rate and the private room rate
At a skilled nursing or long-term care facility	**Member costs**
Inpatient services	▪ **For days paid by Medicare:** No member costs until Plan benefit limit is reached ▪ **For days *not* paid by Medicare:** 20% coinsurance until Plan benefit limit is reached The Plan benefit limit is $13,400 each calendar year

Table 6 lists examples of the services and supplies covered under the benefit for inpatient care.

Table 6. Examples of covered inpatient services

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

The Plan covers inpatient hospital stays covered by Medicare. If you exhaust your Medicare benefits for inpatient hospital care, UniCare will review your case to determine eligibility for continued benefits. See pages 108-109 for a description of how UniCare reviews inpatient admissions and other services.

✕ Restrictions:

- There is no coverage for custodial care. **Custodial care** is a level of care that is chiefly designed to assist with activities of daily living and cannot reasonably be expected to greatly restore health or bodily function.
- Private rooms are covered only if medically necessary.
- There is no coverage for private duty nursing.
- 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.
- Whether or not Medicare pays, the coinsurance for skilled nursing facilities and long-term care facilities doesn't count toward the coinsurance limit.

Laboratory services (lab work) and radiology

Lab work and radiology services (such as X-rays) are covered when prescribed by a physician.

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.

	Member costs
Emergency room	No member costs
Hospital inpatient	No member costs
Hospital outpatient or non-hospital-owned facility	No member costs

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 inpatient benefit (pages 54-55).

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.

Maternity care is often billed as a global (all-inclusive) service. When this is the case, you owe an office visit copay for the first visit but not for subsequent visits with the original doctor. However, services from other providers are not covered within the global service arrangement. Those services are billed separately and additional member costs (copays and coinsurance) may apply.

Medical care outside the U.S.

The Plan covers emergency services you get outside of the United States. Emergency services are covered at 100% of UniCare's allowed amounts after any copay amounts that apply.

To receive payment for emergency services outside the U.S., you or the provider must file a claim for each service. If we get a bill from the provider, we will pay the provider directly.

If you file the claim yourself, your claim must include written proof of the service and of your payment, as described on pages 106-107. If your bill has information in a foreign language, please provide a translation, if possible.

Charges for non-U.S. services are converted to U.S. dollars using the exchange rate found on **www.oanda.com**. The claim is paid based on these converted amounts.

Restrictions:

- There is no coverage for elective services received outside the U.S.
- Ambulance transportation is covered only in an emergency, and only for transportation to the nearest facility that can treat the condition.
- There is no coverage for ambulance transportation, including air ambulance, to a specified or preferred facility if a nearer facility can provide treatment.
- Repatriation expenses are not covered.

Medical services (if not listed elsewhere)

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

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

Neuropsychological (neuropsych) testing

Neuropsych testing is covered as a medical benefit when the testing is for a condition such as head injury, stroke or dementia, and when it is performed by a medical provider. When testing is for a condition like depression and is performed by a behavioral health provider, such as a psychiatrist, it is covered as a behavioral health benefit (see pages 85-86 for coverage details).

Occupational therapy

The Plan covers occupational 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 occupational therapist or occupational therapy assistant (under the direction of an occupational therapist).

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

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

	Member costs
Occupational therapy	▪ **If Medicare pays:** No member costs ▪ **If Medicare does *not* pay:** 20% coinsurance

✕ Restrictions:

- There is no coverage for:
  - Group occupational therapy
  - Sensory integration therapy
  - Occupational therapy to treat a chronic condition when that treatment is neither curative nor restorative
- Services provided through schools are not covered.

Office visits

Office visits with primary care and specialty care providers are covered. See “Doctor and other medical provider services” on page 40 for coverage information.

Outpatient hospital services (if not listed elsewhere)

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

Outpatient hospital services are services provided by a hospital that are usually performed within a single day and don't require an overnight stay. However, an overnight stay for observation would be considered outpatient care if you are not actually admitted to the hospital.

	Member costs
Outpatient hospital services (if not listed elsewhere)	No member costs

Oxygen

Oxygen and its administration are covered.

	Member costs
✓ **Oxygen**	▪ **Preferred vendors:** No member costs ▪ **Non-preferred vendors:** 20% coinsurance

✕ Restrictions:

- The 20% coinsurance doesn't count toward the coinsurance limit.
- Oxygen equipment required for use on an airplane or other means of travel is not covered.

✓ **Use Medicare suppliers or UniCare preferred vendors** (page 23) – Use a UniCare preferred vendor if there is no Medicare supplier available.

Look for Medicare suppliers at medicare.gov. Find a list of UniCare preferred vendors at unicaremass.com.

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, preapprovals, and provider payment methods.

Personal Emergency Response Systems (PERS)

Installation and rental of a personal emergency response system (PERS) are covered when a doctor's letter attesting to its medical necessity is included with the claim.

	Member costs
PERS installation	20% coinsurance (limited to $50 each calendar year)
PERS rental	No member costs (limited to $40 a month)

Restrictions:

- The 20% coinsurance doesn't count toward the coinsurance limit.
- There is no coverage for the purchase of a PERS unit.

Physical therapy

The Plan covers physical therapy on a short-term basis when the potential for functional gain exists. One-on-one therapies are covered only when ordered by a physician and administered by a licensed physical therapist or physical therapy assistant (under the direction of a physical therapist).

Physical therapy is hands-on treatment to relieve pain, restore function and/or minimize disability resulting from disease or injury to the neuromuscular and/or musculoskeletal system, or the loss of a body part. Physical therapy may include direct manipulation, exercise, movement, and/or other physical modalities.

	Member costs
Physical therapy	▪ **If Medicare pays:** No member costs ▪ **If Medicare does *not* pay:** 20% coinsurance

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:
  - Group physical therapy
  - Services provided by athletic trainers
  - Massage therapy and services provided by a massage therapist or neuromuscular therapist
  - Physical therapy to treat 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.
- Services provided by a chiropractor are considered chiropractic care, not physical therapy.
- Services provided through schools are not covered.

Prescription drugs

Benefits for most prescription drugs are administered by SilverScript. See Part 5 (pages 137-144) for benefits information.

Preventive care

The Plan covers preventive or routine office visits, physical exams and other related preventive services that are recommended by the U.S. Preventive Services Task Force.

Covered preventive services are covered at 100% of the allowed amount, without any member costs. Preventive exams are covered according to the schedule issued by Massachusetts Health Quality Partners.

The schedule and guidelines for covered preventive services appears in Chapter 6.

	Member costs
Preventive care	No member costs

✕ Restrictions:

- Not all preventive healthcare services are recommended for everyone. You and your doctor should decide what care is appropriate for you.
- Claims must be submitted with the appropriate preventive diagnosis and procedure codes in order to be paid at 100%.
- If you are treated for an existing illness, injury or condition during your preventive exam, you may have to pay member costs for those non-preventive services.

Prosthetics and orthotics

Prosthetics and orthotics, including braces, are covered if they are prescribed by a physician as medically necessary.

Prosthetics replace part of the body or replace all or part of the function of a permanently inoperative, absent, or impaired part of the body. Breast prosthetics and artificial limbs are prosthetics.

Orthotics are devices used to restrict, align or correct deformities and/or to improve the function of moveable parts of the body. They are often attached to clothing and/or shoes, may assist in movement, and are sometimes jointed. Orthotics include braces, splints and trusses.

	Member costs
Breast prosthetics	No member costs
Orthopedic shoe with attached brace	No member costs
Other prosthetics and orthotics (including mastectomy bras)	▪ **If Medicare pays:** No member costs ▪ **If Medicare does *not* pay:** 20% coinsurance

✕ Restrictions:

- Orthotics must be:
  - Ordered by a physician
  - Custom molded and fitted to your body
  - Used only by you
- There is no coverage for replacement prosthetics and orthotics except when needed due to normal growth or pathological change (a change in your medical condition that requires a prescription change). Supporting documentation is required.
- 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

Pulmonary rehabilitation (rehab) programs

Pulmonary rehab programs use a combination of education and exercise to help improve respiratory function in people diagnosed with breathing problems.

	Member costs
Pulmonary rehab programs	No member costs

A pulmonary rehab program must:

- ❑ Be ordered by a physician
- ❑ Be operated by a licensed clinic or hospital
- ❑ Meet the generally accepted standards of pulmonary rehab

This benefit covers the active rehabilitation phase of the program, which is usually three consecutive months.

✕ Restrictions:

- To qualify for a pulmonary rehab program, you must have a diagnosed breathing problem such as chronic obstructive pulmonary disease (COPD) or pulmonary fibrosis.
- Pulmonary rehab programs are limited to 36 visits (three visits per week for 12 weeks).
- There is no coverage for the *maintenance* phase of a pulmonary rehab program. Coverage is for the *active* phase only.

Radiation therapy

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

	Member costs
Radiation therapy	No member costs

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 54-55).

Retail health clinics

Retail health clinics are clinics located in retail stores or pharmacies that offer basic medical services on a walk-in basis. See “Emergency care / urgent care” on pages 42-43 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 inpatient benefit (pages 54-55).

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.

	Member costs
Sleep studies	No member costs

Speech therapy

Services for the diagnosis and treatment of speech, hearing and language disorders (speech-language pathology services) are covered when provided by a licensed speech-language pathologist or audiologist. The services must be ordered by a physician and provided in a hospital, clinic or private office.

	Member costs
Speech therapy	No member costs

Covered speech therapy services include:

- ❑ Assessment of and remedial services for speech defects caused by either a physical disorder or by autism spectrum disorder
- ❑ Speech rehabilitation, including physiotherapy, following laryngectomy

✕ Restrictions:

- There is no coverage for:
  - Cognitive rehabilitation, except as related to COVID-19
  - Speech therapy to treat a chronic condition when that treatment is neither curative nor restorative
- Services provided through schools are not covered.

Surgery

The surgery benefit covers facility charges and surgeon fees for operative services including care before, during and after surgery.

	Member costs
In Massachusetts	No member costs
Outside Massachusetts	▪ **Medicare participating:** No member costs ▪ **Medicare non-participating:** 20% of the difference between the Plan's allowed amount and the provider's charge

Reconstructive breast surgery for all stages of mastectomy are covered under this benefit. See page 160 for details.

Restrictions:

- Coverage for reconstructive and restorative surgery – surgery intended to improve or restore bodily function or to correct a functional physical impairment that has been caused by either a congenital anomaly or a previous surgical procedure or disease – is limited to the following:
  - Correction of a functional physical impairment due to previous surgery or disease
  - Reconstruction of defects resulting from surgical removal of an organ or body part for the treatment of cancer. Such restoration must be within five years of the removal surgery.
  - Correction of a congenital birth defect that causes functional impairment for a minor dependent child
- Devices that are not directly involved in the surgery, such as artificial limbs, artificial eyes or hearing aids may be covered under a different benefit, such as prosthetics.
- Cosmetic services are not covered, with the exception of treatment for HIV-associated lipodystrophy and the initial surgical procedure to correct appearance that has been damaged by an accidental injury.
- Coverage for assistant surgeon services is limited, as follows:
  - The services of an assistant surgeon must be medically necessary.
  - The assistant surgeon must be a licensed provider (e.g., physician, physician assistant) acting within the scope of his or her license and trained in a surgical specialty related to the procedure.
  - The assistant surgeon serves as the first assistant surgeon to the primary surgeon during a surgical procedure.
  - Only one assistant surgeon is covered per procedure. Second and third assistants are not covered.
  - Interns, residents and fellows are not covered as assistant surgeons.

Tobacco cessation counseling

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

	Member costs
Tobacco cessation counseling	No member costs (limited to 300 minutes in a calendar 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 face-to-face 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 claim forms from unicaremass.com.

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

Restrictions:

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

Transplants

Benefits are payable – subject to any copays, coinsurance and benefit limits – for necessary medical expenses incurred for the transplanting of a human organ.

	Member costs
At a Medicare-certified transplant facility	No member costs
At other hospitals	20% coinsurance

Clinical services personnel are available to support you and your family before the transplant procedure and through the recovery period. Clinical services can help with:

- ❑ Reviewing your ongoing needs
- ❑ Finding out about services while you await a transplant
- ❑ Getting information about your Medicare benefits
- ❑ Guiding you on home care plans, as appropriate

Restrictions:

- The 20% coinsurance doesn't count toward the coinsurance limit.

Human organ donor services

Benefits are payable – subject to any 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, and regulations established by the Massachusetts Department of Public Health.

Travel clinics

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

	Member costs
Travel clinic visits	No member costs
Immunizations at travel clinics	No member costs

✕ Restrictions:

- Unless you are pregnant, there is no coverage for blood tests (titers) to determine if you need an immunization. See **Immunization titers** on page 96.

Urgent care

The Plan covers urgent care services. **Urgent care** refers to services you get when your health is not in serious danger but you need immediate medical attention. You can get urgent care services at various locations that offer walk-in medical care, but your member costs will vary. See “Emergency care / urgent care” on pages 42-43 to find out about the different types of providers that offer urgent care services.

Walk-in clinics

Walk-in clinics are sites that offer medical care on a walk-in basis, so no appointment is needed. See “Emergency care / urgent care” on pages 42-43 for information about the different types of walk-in clinics.

Wigs

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

	Member costs
Wigs	20% coinsurance (limited to $350 in a calendar year)

✕ Restrictions:

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

Chapter 6: Covered preventive services

The Plan covers preventive or routine office visits, physical exams, and other related preventive services listed in Table 7. Preventive exams are covered according to the schedule issued by Massachusetts Health Quality Partners.

The preventive services listed below are covered at 100% of the allowed amount. The table also shows gender, age, and frequency recommendations.

Important! Your doctor must submit claims with preventive diagnosis and procedure codes to be covered at 100% as a preventive service. Preventive services don't include services to treat an existing condition. If, during your preventive visit, you get services to treat an existing condition, you may owe member costs for those services.

Please note that the preventive services listed here are not recommended for everyone. You and your doctor should decide what care is appropriate for you.

Table 7. Preventive care schedule

	Recommendations			
Preventive service	**Males**	**Females**	**Age**	**How often?**
Abdominal aortic aneurysm screening	■	■	65 and older	One time
Alcohol misuse screening and counseling	■	■		Part of the preventive exam
Anemia screening		■		Part of the preventive exam
Anxiety screening	■	■	8 to 18 years	Part of the preventive exam for children and adolescents
Blood pressure screening	■	■		Part of the preventive exam
Bone density testing – Screening for osteoporosis		■	40 and older	Every 2 years
BRCA risk assessment and genetic counseling / testing – For breast cancer		■		One time
Breast cancer counseling and preventive medications		■		Part of the preventive exam
Breastfeeding counseling		■		Part of the preventive exam
Cardiovascular disease prevention – Nutritional and physical activity counseling	■	■		For high-risk adults; part of the preventive exam
Chlamydia screening		■		Every 12 months

	Recommendations			
Preventive service	**Males**	**Females**	**Age**	**How often?**
Cholesterol screening	■	■		Every 12 months
Colorectal cancer screening Includes colonoscopies, fecal occult blood testing, and other related services and tests Colonoscopies for members under 45 are covered under limited circumstances (see page 92)	■	■	45 and older	▪ Every 12 months for fecal occult blood test
Depression screening – Includes screening for perinatal depression (during and after pregnancy)	■	■		Part of the preventive exam
Developmental and behavioral screening	■	■		Part of the preventive exam for children
Diabetes screenings: ▪ Type 2 diabetes ▪ Gestational diabetes in pregnant women	■	■		Part of the preventive exam
Domestic violence screening		■		For women of childbearing age; part of the preventive exam
Drug use screening	■	■		Part of the preventive exam
Fluoride supplements – Starting at the age of primary tooth eruption	■	■	Up to age 5	
Gonorrhea preventive medication	■	■	At birth	For newborns
Gonorrhea screening		■		Every 12 months
Gynecological exams		■		Every 12 months
Hearing screening	■	■	At birth	For newborns
Height, weight and body mass index (BMI) measurements	■	■		Part of the preventive exam
Hepatitis B screening	■	■		
Hepatitis C screening	■	■		
HIV Pre-Exposure Prophylaxis (PrEP) – Includes medications, testing, monitoring, and adherence counseling	■	■		Medications subject to your prescription drug benefit
HIV screening – For the virus that causes AIDS	■	■		

	Recommendations			
Preventive service	**Males**	**Females**	**Age**	**How often?**
HPV (human papillomavirus) testing – For cervical cancer		■	30 and older	Every 5 years for women with normal cytology results
Hypothyroidism screening	■	■	At birth	For newborns
Immunizations	■	■		
Iron supplements for anemia	■	■	6 to 12 months	For at-risk babies
Lab tests – Other covered screening lab tests: ▪ Hemoglobin ▪ Urinalysis ▪ Chemistry profile, including: ▫ Complete blood count (CBC) ▫ Glucose ▫ Blood urea nitrogen (BUN) ▫ Creatinine transferase alanine amino (SGPT) ▫ Transferase asparate amino (SGOT) ▫ Thyroid stimulating hormone (TSH)	■	■		Part of the preventive exam
Lead exposure screening	■	■		For children
Lung cancer scan – CT lung scan for adults who have smoked	■	■	50-80 years	Every 12 months
Mammograms – Screening for breast cancer		■	35 and older	▪ Once between the ages of 35 and 40 ▪ Yearly after age 40
Nutritional counseling	■	■		For children at high risk of obesity
Obesity screening and counseling	■	■		Part of the preventive exam
Oral health assessment	■	■		Part of the preventive exam for children
Pap smears – Screening for cervical cancer		■		Every 12 months
Phenylketonuria (PKU) screening	■	■	At birth	For newborns

	Recommendations			
Preventive service	**Males**	**Females**	**Age**	**How often?**
Preventive exams (children)	■	■	Up to age 19	▪ Four exams while the newborn is in the hospital ▪ Five exams until 6 months of age; then ▪ Every two months until 18 months of age; then ▪ Every three months from 18 months of age until 3 years of age; then ▪ Every 12 months from 3 years of age until 19 years of age
Preventive exams (adults)	■	■	19 and older	Every 12 months
Prostate cancer screening – Digital rectal exam and PSA test	■		50 and older	▪ Digital exam – Part of the preventive exam ▪ PSA test – Every 12 months
Rh incompatibility screening		■		For pregnant women
Sexually transmitted infections (STI) counseling	■	■		Part of the preventive exam
Sickle cell disease screening	■	■	At birth	For newborns
Skin cancer behavioral counseling	■	■		Part of the preventive exam
Syphilis screening	■	■		
Tuberculosis screening	■	■		
Urinary tract infections (UTI) screening – Asymptomatic bacteriuria		■		During pregnancy
Vision screening	■	■		Part of the preventive exam for children
Vision screening (instrument-based)	■	■	3-5 years	

PART 3:

YOUR BEHAVIORAL HEALTH BENEFITS

Description of coverage for mental health and substance use disorder services

For questions about any of the information in Part 3 of this handbook, please call UniCare Member Services at 800-442-9300.

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Chapter 7: Using your benefits for behavioral health

Coverage for behavioral health services

Behavioral health services are services that treat mental health and substance use disorder conditions. The Plan offers comprehensive benefits for behavioral health services. UniCare has partnered with **Carelon Behavioral Health** to establish a network of experienced behavioral health providers.

Important! Unlike your medical benefits, your behavioral health coverage is a network-based benefit. This means that your member costs depend on whether or not you use a provider in the Carelon Behavioral Health network.

Your coverage is highest when you use providers in Carelon's provider network. When you use out-of-network providers, your benefits are lower and you risk being balance billed. See page 21 to find out more about balance billing.

About behavioral health providers

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

You can call the provider of your choice directly to schedule an appointment.

Look for Carelon Behavioral Health in-network providers at unicaremass.com. You can also call UniCare Member Services at 800-442-9300 for help.

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

Examples of accepted behavioral health licenses

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

About filing your claims

Some out-of-network providers may bill you for services instead of submitting claims to UniCare. If this happens, you will need to submit the claims yourself. See pages 106-107 for instructions on how to submit claims to UniCare.

Getting preapproval for behavioral health services

Under some circumstances, such as for services that Medicare doesn't cover or when Medicare's benefits have been exhausted, behavioral health services may need to be preapproved. Preapproval review confirms that a service is eligible for benefits.

A service doesn't need preapproval if:

- ❑ The service is covered by Medicare, and
- ❑ You are using a Medicare participating provider.

Otherwise, you must meet the requirements listed in Table 8. If someone (you or your provider) doesn't notify UniCare when a preapproval review is required, your benefits may be reduced or not paid at all.

To get assistance with preapprovals 24 hours a day, seven days a week, your provider should call UniCare at 800-442-9300 (TTY: 711).

Preapprovals for behavioral health services

Table 8 lists behavioral health services that may need preapproval review if they are not covered by Medicare. Note that the requirements are different for in-network and out-of-network providers.

What is a DPH-licensed provider? The Massachusetts Department of Public Health (DPH) issues licenses to Massachusetts facilities that provide healthcare services. To be licensed, facilities must meet specific quality and safety standards.

Table 8. Behavioral health preapproval requirements (if not covered by Medicare)

Behavioral health service	With in-network providers	With out-of-network providers
Inpatient services for mental health treatment		
▪ Acute residential treatment ▪ Inpatient psychiatric services	Needs preapproval	Needs preapproval
▪ Community-based acute treatment (CBAT) ▪ Transitional care units (TCU)	▪ **In Massachusetts:** Notify UniCare within 72 hours ▪ **Outside Massachusetts:** Needs preapproval	▪ **In Massachusetts:** N/A ▪ **Outside Massachusetts:** Needs preapproval
▪ Crisis stabilization units (CSU)	Needs preapproval for stays over 5 days	Needs preapproval for stays over 5 days
Inpatient services for substance use disorders (adults and adolescents)		
▪ Acute residential withdrawal management (ASAM level 3.7 detox) ▪ Clinical stabilization services (CSS) (ASAM level 3.5) ▪ Dual diagnosis acute treatment (DDAT) (ASAM level 3.5) ▪ Inpatient substance use disorder services, medically managed (ASAM level 4 detox)	▪ **In Massachusetts:** Notify UniCare within 48 hours ▪ **Outside Massachusetts:** Needs preapproval	▪ **DPH-licensed providers in Massachusetts:** Notify UniCare within 48 hours ▪ **All other OON providers:** Needs preapproval
▪ Crisis stabilization units (CSU)	Needs preapproval for stays over 5 days	Needs preapproval for stays over 5 days

Behavioral health service	With in-network providers	With out-of-network providers
Outpatient services (including office services)		
▪ Acupuncture withdrawal management ▪ Community support programs (CSP) ▪ Day treatment	N/A	Needs preapproval
▪ Applied Behavior Analysis (ABA) ▪ Dialectical behavioral therapy (DBT) ▪ Family stabilization teams (FST) ▪ Partial hospitalization programs for mental health conditions (PHP) ▪ Psychiatric visiting nurse services ▪ Transcranial magnetic stimulation (TMS)	Needs preapproval	Needs preapproval
▪ Partial hospitalization programs for substance use disorders (PHP) (ASAM level 2.5)	▪ **In Massachusetts:** Notify UniCare within 48 hours ▪ **Outside Massachusetts:** Needs preapproval	▪ **In Massachusetts:** Notify UniCare within 48 hours ▪ **Outside Massachusetts:** Needs preapproval
▪ Intensive outpatient programs (IOP) ▪ Structured outpatient addictions programs (SOAP)	Notify UniCare within 48 hours	▪ **DPH-licensed providers in Massachusetts:** Notify UniCare within 48 hours ▪ **All other OON providers:** Needs preapproval

Case management

Behavioral health case management is a program to help you or a family member with your mental health or substance use needs. The goal of the program is to help you be your best, and get the most out of treatment. The program is free for UniCare members, and you don't have to join if you don't want to.

What case managers do…

- Help organize care among your doctors, nurses, and social workers
- Give you information about mental health and substance use services and other community services
- Help you in getting the mental health and substance use services that work best for you
- Help you to follow the instructions from your doctor, nurse, or social worker
- Work with you to get help from local programs
- Help you with a plan to remember to take your medication
- With your permission, keep your primary care provider and psychiatrist updated on your progress

Case management can help if you…

- Have been in the hospital for mental health or substance use reasons
- Have trouble getting the care that works best for you
- Have mental health or substance use issues and also have medical issues
- Need support to help you follow your doctor, nurse, or social worker's advise
- Are pregnant or recently were pregnant and needed mental health or substance use services

Behavioral health case managers are experienced and licensed nurses, social workers, and mental health experts. To find out more about behavioral health care management, call UniCare at 800-442-8300 and ask to speak with a case manager.

Quality programs

UniCare and Carelon Behavioral Health work together to keep improving the quality of care and services provided for you. We want to ensure that every UniCare member receives safe, effective and responsive treatments to address their healthcare needs. We strive to:

- ❑ Ensure you receive timely service from us and our providers, and that you are satisfied.
- ❑ Ensure that our services are easy to access and meet your cultural needs.
- ❑ Improve any deficits in the services you receive.

You can find more information about Carelon's quality programs at www.carelonbehavioralhealth.com.

Chapter 8: Summary of costs for behavioral health services

Table 9. Summary of covered behavioral health services

Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 21).

Service	Member costs with in-network providers	Member costs with out-of-network providers	See page
☎ **Applied Behavior Analysis (ABA)**	▪ **Visits 1-4:** no member costs ▪ **After 4:** $10 copay	▪ **Visits 1-15:** 20% coinsurance ▪ **After 15:** 50% coinsurance	80
Emergency service programs (ESP)	No member costs	No member costs	81
☎ **Inpatient care**	No member costs	20% coinsurance	82
Medication-assisted treatment (MAT)	No member costs	No member costs	84
Medication management (outpatient)	▪ **Visits 1-4:** no member costs ▪ **After 4:** $5 copay	▪ **Visits 1-15:** 20% coinsurance ▪ **After 15:** 50% coinsurance	84
☎ **Outpatient – office services**	▪ **Visits 1-4:** no member costs ▪ **After 4:** $10 copay	▪ **Visits 1-15:** 20% coinsurance ▪ **After 15:** 50% coinsurance	85
☎ **Outpatient – other services**	No member costs	20% coinsurance	86
Substance use disorder assessment / referral	No member costs	No member costs	87
Therapy (outpatient)			88
▪ Individual therapy	▪ **Visits 1-4:** no member costs ▪ **After 4:** $10 copay	▪ **Visits 1-15:** 20% coinsurance ▪ **After 15:** 50% coinsurance	
▪ Family therapy	▪ **Visits 1-4:** no member costs ▪ **After 4:** $10 copay	▪ **Visits 1-15:** 20% coinsurance ▪ **After 15:** 50% coinsurance	
▪ Group therapy	▪ **Visits 1-4:** no member costs ▪ **After 4:** $5 copay	▪ **Visits 1-15:** 20% coinsurance ▪ **After 15:** 50% coinsurance	

Chapter 9: Covered behavioral health services

Applied Behavior Analysis (ABA)

Applied Behavior Analysis (ABA) is a specialized therapy used in the treatment of autism spectrum disorders that focuses on improving appropriate behaviors and minimizing negative behaviors.

	With in-network providers	With out-of-network providers
☎ **Applied Behavior Analysis (ABA)**	▪ **Visits 1-4:** no member costs ▪ **After 4:** $10 copay	▪ **Visits 1-15:** 20% coinsurance ▪ **After 15:** 50% coinsurance

ABA is administered by a licensed clinician, such as a board-certified behavior analyst (BCBA), working in association with a paraprofessional. The licensed clinician performs an assessment and develops a treatment plan which is carried out by the paraprofessional.

✕ Restrictions:

- The paraprofessional carrying out the treatment plan must be supervised by a licensed clinician.
- If you have more than one office service from the same provider on the same day, you only owe one copay.

☎ **Applied Behavior Analysis (ABA) may need preapproval if not covered by Medicare.** Your provider should contact UniCare if you will be having ABA services that aren't covered by Medicare. See the preapprovals list on pages 79-81.

Autism spectrum disorders

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

Services for autism spectrum disorders are covered like any other behavioral health or physical condition. Coverage is subject to all pertinent provisions of the Plan, including use of participating providers, preapproval reviews, benefit limitations, and provider payment methods. Medical services needed for diagnosis and treatment are covered as a medical benefit.

Diagnosis and treatment of autism spectrum disorders may include (but are not limited to) the following services:

- ❑ **Applied Behavior Analysis (ABA)** – A specialized therapy used in the treatment of autism spectrum disorders that focuses on improving appropriate behaviors and minimizing negative behaviors.
- ❑ **Psychiatric services** – Services that focus on treating behaviors that pose a danger to self, others and/or property or that impair daily functioning, such as:
  - Diagnostic evaluations and assessment
  - Treatment planning
  - Referral services
  - Medication management
  - Inpatient/24-hour supervisory care
  - Partial hospitalization/day treatment
  - Intensive outpatient treatment
  - Services at an acute residential treatment facility
  - Individual, family, therapeutic group, and provider-based case management services
  - Psychotherapy, consultation, and training session for parents
  - Paraprofessional and resource support for the family
  - Crisis intervention
  - Transitional care

Emergency service programs

Important! Always seek emergency care if you (or someone covered under your Plan) present a significant risk to yourself or others. In a life-threatening emergency, go to the closest emergency room (see pages 42-43 for benefits information). If you call UniCare seeking non-life threatening emergency care, UniCare will connect you with appropriate services within six hours.

Seek urgent care if you have a condition that may become an emergency if it is not treated quickly. Call UniCare at 800-442-9300 if you need help finding an available in-network provider. UniCare will help you schedule an appointment within 48 hours of your call.

In Massachusetts, **Emergency service programs (ESPs)** provide behavioral health crisis assessment, intervention and stabilization services on short notice. These programs are staffed by behavioral health providers who can evaluate a member in their home, office, or at some other community-based location, like a school. Evaluations can also be performed at a hospital emergency room, and many Massachusetts hospitals contact one of these programs if an ER patient needs behavioral health intervention.

	With in-network providers	With out-of-network providers
Emergency service programs in Massachusetts	No member costs	No member costs

ESPs provide crisis assessment within one hour of being contacted. They will evaluate the member to determine what type of service is needed, and help access the service. For example, if a suicidal member calls an ESP, a provider will come to their location and perform an evaluation. If inpatient care is needed, the ESP will find a bed and get the necessary preapproval.

To contact an ESP, call 877-382-1609 and enter your Massachusetts ZIP code to get the toll-free number for the ESP in your area.

✕ Restrictions:

- If you're admitted to an out-of-network hospital from the emergency room and there are no in-network hospitals available, you won't owe any coinsurance.
- UniCare will pay up to the out-of-network allowed amount for services you get at an out-of-network inpatient facility. You may be responsible for paying charges over the allowed amount (that is, the facility may balance bill you).

☎ Notify UniCare if you're admitted to the hospital from the emergency room.
Your provider should notify UniCare within 24 hours of your admission.

Inpatient behavioral health care (hospital admissions)

Inpatient behavioral health care addresses behavioral health conditions with severe symptoms that are expected to improve with intensive, short-term treatment. These are services you get when staying overnight (that is, you've been admitted) at an acute care hospital, psychiatric hospital, substance use disorder facility, or residential facility. Most of these services are available for both adults and adolescents, unless otherwise noted.

	With in-network providers	With out-of-network providers
☎ Inpatient behavioral health care	No member costs	20% coinsurance

Table 10 lists the services and programs covered under this benefit.

Table 10. Behavioral health inpatient services

Inpatient service	Description
Acute residential treatment	Short-term, 24-hour programs that provide treatment within a protected and structured environment
Acute residential withdrawal management [ASAM level 3.7 detox]	Drug or alcohol withdrawal (detox) that is medically monitored, for members at risk of severe withdrawal
Clinical stabilization services for substance use disorder (CSS) [ASAM level 3.5]	Clinically-managed detox and recovery services provided in a non-medical setting
Community-based acute treatment (CBAT)	Treatment for children and adolescents with serious behavioral health disorders who need a protected and structured environment
Crisis stabilization units (CSU)	24-hour observation and supervision when inpatient hospital care isn't needed
Dual diagnosis acute treatment (DDAT) [ASAM level 3.5]	Clinically-managed detox and recovery services for those with both a substance use and mental health condition who require a protected and structured environment
Inpatient psychiatric services	Admission to an acute care hospital or psychiatric hospital for treatment of a mental health condition
Inpatient substance use disorder services, medically managed [ASAM level 4 detox]	24-hour medical care for substance withdrawal provided at an acute care hospital
Observation stays	A hospital stay that allows for extended assessment or observation when an inpatient admission may not be appropriate or needed. Observation stays typically last 24 hours or less, but can be for up to 72 hours.
Transitional care units (TCU)	Facilities that help children and adolescents transition from an acute care facility to home, a residential program, or foster care

✕ Restrictions:

- If you're admitted to an out-of-network hospital from the emergency room and there are no in-network hospitals available, you won't owe any coinsurance.
- There's no coverage for non-acute residential treatment. Examples of such treatment include:
  - Clinically-managed, low-intensity residential services
  - Clinically-managed, population-specific, high-intensity residential services
  - Recovery residences
  - Sober homes

- There's no coverage for treatment performed in a non-conventional setting. Examples of non-conventional settings include:
  - Spas or resorts
  - Therapeutic or residential schools
  - Educational, vocational, or recreational locations
  - Day care or preschools
  - Outward Bound
  - Wilderness, camp or ranch programs

☎ **Behavioral health inpatient services may need preapproval if not covered by Medicare.** Your provider should notify UniCare when you get behavioral health inpatient services that aren't covered by Medicare. See the preapprovals list on pages 75-77.

Medication-assisted treatment (MAT)

The Plan covers **medication-assisted treatment (MAT)**, the long-term prescribing of medication as an alternative to the opioid on which a member was dependent. This treatment is usually dispensed through **opiate treatment programs (OTP)** that are licensed to distribute and administer these medications.

	With in-network providers	With out-of-network providers
Medication-assisted treatment from opiate treatment programs	No member costs	No member costs

When you get this treatment through an OTP, both the drug and its administration are covered at no member cost. You can also get this treatment from a provider in an office setting, but in that case you will be responsible for the member costs associated with a provider visit.

☞ **Important!** You owe costs for an office visit when you get MAT from an individual provider. In addition, you'll need to fill a prescription for the medication at a pharmacy.

Medications covered under this benefit include methadone, buprenorphine (Suboxone), and naltrexone (Vivitrol).

Medication management (outpatient)

The Plan covers medication management visits, including medication management visits that include outpatient therapy. **Medication management** consists of visits with a behavioral health provider who can evaluate and prescribe medication, if needed. These services may be handled in person or through virtual care (telehealth).

	With in-network providers	With out-of-network providers
Medication management	▪ **Visits 1-4:** no member costs ▪ **After 4:** $5 copay	▪ **Visits 1-15:** 20% coinsurance ▪ **After 15:** 50% coinsurance

Medication management also includes **ambulatory withdrawal management**, more commonly known as **outpatient detox**. Ambulatory withdrawal management is a drug or alcohol withdrawal process in which a member has daily visits with a provider throughout withdrawal.

✕ Restrictions:

- Therapy visits, office services and medication management visits all count toward the 4-visit limit (in-network) or the 15-visit limit (out-of-network), whichever applies.

Outpatient – office services

The Plan covers medically necessary office services to treat mental health and substance use disorder conditions. These services must be provided in an appropriate setting such as a medical office, home, hospital, other medical facility, or through virtual care (telehealth).

	With in-network providers	With out-of-network providers
☎ **Office services**	▪ **Visits 1-4:** no member costs ▪ **After 4:** $10 copay	▪ **Visits 1-15:** 20% coinsurance ▪ **After 15:** 50% coinsurance

Covered office services include the services and programs listed in Table 11.

Table 11. Behavioral health outpatient office services

Office service	Description
Acupuncture withdrawal management (detox)	The use of acupuncture to ease the symptoms of drug or alcohol withdrawal
Dialectical behavioral therapy (DBT)	A combination of therapies designed to help change unhealthy behaviors and treat people suffering from behavioral health disorders
Neuropsychological testing	Testing to find out if a problem with the brain is affecting one's ability to reason, concentrate, solve problems, or remember
Psychiatric visiting nurse (VNA) services	Short-term treatment delivered in the home or living environment to treat behavioral health disorders with medication
Psychological testing	Standardized assessment tools to diagnose and assess overall psychological functioning

Office service	Description
Transcranial magnetic stimulation (TMS)	A non-invasive method of brain stimulation used to treat major depression

✕ Restrictions:

- Therapy visits, office services and medication management visits all count toward the 4-visit limit (in-network) or the 15-visit limit (out-of-network), whichever applies.
- If you have more than one office service from the same provider on the same day, you only owe one copay.

☎ Behavioral health outpatient services may need preapproval if not covered by Medicare. Your provider should contact UniCare if you will be having a behavioral health office service that isn't covered by Medicare. See the preapprovals list on pages 75-77.

Outpatient – other services

Outpatient services for behavioral health conditions don't require an inpatient hospital admission or overnight stay, but they do require more intensive support than other kinds of behavioral health care. Most of these services are available for both adults and adolescents, unless otherwise noted.

	With in-network providers	With out-of-network providers
☎ **Outpatient services**	No member costs	20% coinsurance

Covered outpatient services include the types of services and programs listed in Table 12.

Table 12. Behavioral health outpatient other services

Outpatient service	Description
Community support programs (CSP)	Programs to help members access and use behavioral health services
Day treatment	Behavioral health programs offering structured, goal-oriented treatment that focuses on improving one's ability to function in the community
Electroconvulsive therapy (ECT)	Psychiatric treatment in which seizures are electrically induced in patients to provide relief from mental disorders
Family stabilization team (FST)	Programs offering intensive services in the home to help children, adolescents and their families deal with complex life stressors

Outpatient service	Description
Intensive outpatient programs (IOP) ▪ For mental health ▪ For substance use disorder [ASAM level 2.1]	Programs that offer thorough, regularly-scheduled treatment in a structured environment. These programs offer at least three hours of therapy a day, up to seven days a week
Partial hospitalization programs (PHP) ▪ For mental health ▪ For substance use disorder [ASAM level 2.5]	Non-residential, structured outpatient psychiatric and substance use programs that are more intensive than one would get in a doctor's office, but that are an alternative to inpatient care. These programs offer at least five hours of therapy a day, up to seven days a week.
Structured outpatient addictions program (SOAP)	Non-residential, structured substance use disorder programs that are more intensive than one would get in a doctor's office, but that are an alternative to inpatient care. These programs offer at least three hours of therapy a day, up to seven days a week.

✕ Restrictions:

- There's no coverage for treatment performed in a non-conventional setting. Examples of non-conventional settings include:
  - Spas or resorts
  - Therapeutic or residential schools
  - Educational, vocational, or recreational locations
  - Day care or preschools
  - Outward Bound
  - Wilderness, camp or ranch programs

☎ **Behavioral health outpatient services may need preapproval if not covered by Medicare.** Your provider should contact UniCare if you will be having a behavioral health outpatient service that isn't covered by Medicare. See the preapprovals list on pages 75-77.

Substance use disorder assessment / referral

Substance use disorder assessment/referral is a comprehensive assessment of substance use to allow a provider to refer a member to appropriate care.

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

Therapy (outpatient)

The Plan covers medically necessary individual, family, and group therapy. Medication management performed in combination with therapy is also covered. These services must be provided in an appropriate setting such as a medical office, home, hospital, other medical facility, or through virtual care (telehealth).

	With in-network providers	With out-of-network providers
Individual therapy	▪ **Visits 1-4:** no member costs ▪ **After 4:** $10 copay	▪ **Visits 1-15:** 20% coinsurance ▪ **After 15:** 50% coinsurance
Family therapy	▪ **Visits 1-4:** no member costs ▪ **After 4:** $10 copay	▪ **Visits 1-15:** 20% coinsurance ▪ **After 15:** 50% coinsurance
Group therapy	▪ **Visits 1-4:** no member costs ▪ **After 4:** $5 copay	▪ **Visits 1-15:** 20% coinsurance ▪ **After 15:** 50% coinsurance

Restrictions:

- If you have more than one type of therapy on the same day and from the same provider, you only owe one copay. If the copays that apply to the services differ, you owe the higher copay.
- Family and individual therapy must be conducted in a provider's office, a facility or, if appropriate, at a member's home.
- Group therapy sessions must be 50 minutes or less.
- Therapy visits, office services and medication management visits all count toward the 4-visit limit (in-network) or the 15-visit limit (out-of-network), whichever applies.

PART 4:

USING YOUR PLAN

Plan and coverage details

For questions about any of the information in Part 4 of this handbook, please call UniCare Member Services at 800-442-9300.

Administered by

UniCare℠

Chapter 10: Excluded and limited services

This chapter lists services and supplies that are not covered or have limited or restricted coverage under the Plan.

Important! Costs for services that the Plan doesn't cover don't count toward your member costs or your out-of-pocket maximums. Member costs and out-of-pocket maximums only apply to covered services.

Table 13. Excluded, restricted, and limited benefits

Service	What is not covered or has limited coverage
A	
Acne-related services	No coverage for the removal of acne cysts, injections to raise acne scars, cosmetic surgery, dermabrasion or similar services. Services to diagnose or treat the underlying condition causing the acne are covered.
Acupuncture	Covered only as a behavioral health service when acupuncture is used as part of drug withdrawal management
Allowed amounts	No coverage for charges over the Plan's allowed amounts
Alternative treatments	No coverage for alternative treatments that are used in place of conventional medicine, as defined by the National Center for Complementary and Integrative Health (NIH)
Ambulances	▪ The following restrictions apply to emergency transportation: ▫ Based on the severity of your condition, no other form of transportation can safely transport you to the nearest facility. ▫ Air or water ambulance is covered only when your medical condition is such that your health would be endangered by the time needed for ground transportation. ▫ Emergency inter-facility transportation to the nearest appropriate facility may be necessary when your current facility is unable to treat your condition and the treatment is considered a medical emergency. ▪ All ambulance transportation must be medically necessary and must take you to the nearest appropriate hospital or facility. ▪ There is no coverage for transportation that is primarily for the convenience of the individual, individual's family, or physician. ▪ Transfers to a hospital that you prefer (e.g., to be closer to home) are not covered. ▪ Transportation in chair cars or vans is not covered.

Service	What is not covered or has limited coverage
Anesthesia for behavioral health services	Covered for electroconvulsive therapy (ECT) only
Animals	No coverage for expenses related to service animals, pet therapy, or hippotherapy (therapeutic or rehabilitative horseback riding)
Arch supports (e.g., Dr. Scholl's inserts)	Not covered
Assistant surgeons	▪ An assistant surgeon must be a licensed provider (e.g., physician, physician assistant) acting within the scope of his or her license. ▪ Only one assistant surgeon per procedure is covered. Second and third assistants are not covered. ▪ Interns, residents, and fellows are not covered as assistant surgeons.
Athletic trainers	Not covered
B	
Beds / bedding	No coverage for non-hospital beds, orthopedic mattresses, or weighted blankets
Behavioral health services	▪ Primary care visits associated with a behavioral health diagnosis are covered. Otherwise, there is no coverage for the diagnosis, treatment or management of mental health/substance use disorder conditions by medical (non-behavioral health) providers. ▪ No coverage of services for conditions that are not classified in the most current edition of the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) ▪ Other non-covered behavioral health services include: ▫ Services not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance use disorder ▫ Services not consistent with prevailing national standards of clinical practice for the treatment of such conditions ▫ Services not consistent with prevailing professional research which would demonstrate that the service or supplies will have a measurable and beneficial health outcome ▫ Services that typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; or that are consistent with appropriate level-of-care clinical criteria, clinical practice guidelines or best practices as modified from time to time.

Service	What is not covered or has limited coverage
Biofeedback	Not covered to treat behavioral health conditions
Blood	The Plan does not pay for donated blood
Blood pressure cuffs (sphygmomanometers)	Not covered
C	
Cardiac rehab programs	Covered only when started within six months of a cardiac event
Chair cars / vans	No coverage for transportation in chair cars or vans
Chiropractic care	▪ Group chiropractic care is not covered ▪ Services provided by a chiropractor are considered chiropractic care, not physical therapy
Chronic conditions	There is no coverage for physical therapy, occupational therapy or speech therapy to treat a chronic condition when that treatment is neither curative nor restorative
Clinical trials for treatments other than cancer	No coverage for any clinical research trial other than a qualified clinical trial for the treatment of cancer (pages 35-36)
Cognitive rehabilitation	Not covered, except as related to COVID-19 **Cognitive rehabilitation** is treatment to restore function or minimize effects of cognitive deficits including, but not limited to, those related to thinking, learning, and memory.
Colonoscopies for people under age 45	Covered as a preventive service only under limited circumstances, based on clinical review of family and personal history
Computer-assisted communications devices	Not covered
Convenience items	No coverage for convenience items used during a hospital stay, such as telephones, television, computers, and beauty or barber services
Cosmetic services	No coverage for cosmetic procedures or services except for: ▪ Treatment for HIV-associated lipodystrophy ▪ The initial surgical procedure to correct appearance that has been damaged by an accidental injury Cosmetic services are not covered even if they are intended to improve a member's emotional outlook or treat a member's mental health condition. **Cosmetic services** are services done mainly to improve appearance. They don't restore bodily function or correct functional impairment.

Service	What is not covered or has limited coverage
Coverage under another plan or program	No coverage for services provided under another plan, or services that federal, state, or local law mandates must be provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.
Custodial care	Not covered **Custodial care** is a level of care that is chiefly designed to assist with activities of daily living and that cannot reasonably be expected to greatly restore physical health or bodily function.
D	
Dialysis	No coverage for dialysis to treat a behavioral health condition
Dental care	The Plan does not provide benefits for dental care. Medical services that include treatment related to dental care are covered in certain situations (page 37)
Dentures, dental prosthetics, and related surgery	Not covered
Driving evaluations	Not covered
Drugs – off-label	Not covered unless the off-label use meets the Plan's definition of medical necessity or the drug is specifically designated as covered by the Plan. **Off-label** use is the use of a drug for a purpose other than that approved by the FDA.
Drugs – over-the-counter	Not generally covered and never covered without a prescription. Some over-the-counter drugs, such as tobacco cessation products, are covered by the prescription drug plan when you have a prescription (Part 5 of this handbook).
Duplicate (redundant) services	No coverage for multiple charges for the same service or procedure, on the same date A service is considered duplicate (redundant) when the same service is being provided, at the same time, to treat the condition for which it is ordered.

Service	What is not covered or has limited coverage
Durable medical equipment (DME)	Only medically necessary equipment is covered. Types of equipment that are not covered include: ▪ Equipment intended for athletic or recreational use (e.g., exercise equipment, wheelchairs for sports) ▪ Items intended for environmental control or a home modification (e.g., bathroom items, electronic door openers, air cleaners, dehumidifiers, elevators, ramps, stairway lifts) ▪ Added, non-standard features or accessories (e.g., hand controls for driving, transit systems that secure wheelchairs in moving vehicles, wheelchair customizations) ▪ Items specifically designed to be used outdoors (e.g., special wheelchairs for beach access, equipment for use on rough terrain) ▪ Items that serve as backup by duplicating other equipment (e.g., a manual wheelchair as backup for a powered wheelchair) ▪ Equipment upgrades or replacements for items that function properly or that can be repaired
E	
Ear molds	Not covered except when needed for hearing aids for members age 21 and under
Enteral therapy	Prescription and nonprescription enteral formulas are covered only when ordered by a physician for the medically necessary treatment of malabsorption disorders caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. **Enteral therapy** is prescribed nutrition that is administered through a tube that has been inserted into the stomach or intestines.
Equipment transportation and set-up	No coverage for costs associated with transporting and setting up equipment, such as portable X-ray equipment.
Exercise / recreational equipment	No coverage for equipment intended for athletic or recreational use (e.g., exercise equipment, wheelchairs for sports).
Experimental or investigational services or supplies	No coverage for a service or supply that the Plan determines is experimental or investigational; that is, through the use of objective methods and study over a long enough period of time to be able to assess outcomes, the evidence is inadequate or lacking as to its effectiveness. The fact that a physician ordered it, or that this treatment is being tried after others have failed, does not make it medically necessary.

Service	What is not covered or has limited coverage
Eyeglasses and contact lenses	▪ Only covered within six months after an eye injury or cataract surgery ▪ Coverage applies to the initial lenses only ▪ No coverage for deluxe frames or specialty lenses such as progressive or transitional lenses, tinted lenses, anti-reflective coating or polycarbonate lenses
F	
Facility fees	Not covered for office visits or behavioral health office services.
Family members	No coverage for services received from someone who is in your immediate family. Your immediate family consists of you, your spouse and your children, as well as the brothers, sisters and parents of both you and your spouse. This includes any services that providers perform on themselves.
Fees for non-medical services	Fees for non-medical services are not covered. Some examples of these types of fees include: ▪ Day care services ▪ Food services (e.g., diet programs) ▪ Lab handling fees ▪ Membership and joining fees (e.g., Weight Watchers), with the exception of the fitness reimbursement ▪ Record processing fees, unless required by law ▪ Shipping costs (e.g., the cost of shipping eggs or sperm between fertility clinics) ▪ Storage fees ▪ Transportation and set-up costs (e.g., portable X-ray equipment)
Fitness reimbursement	▪ Any family members may have fitness memberships but the reimbursement is paid to the plan enrollee only. ▪ You must participate in physical activity an average of four times or more per month. ▪ Ineligible costs include beach or country club memberships or dues; fees for one-day events; annual or day passes (such as for skiing); spas or spa services; personal or home fitness equipment.
Free or no-cost services	▪ No coverage for any medical service or supply that wouldn't have cost anything if there was no medical insurance ▪ No coverage for services that you have no legal responsibility to pay

Service	What is not covered or has limited coverage
G	
Genetic testing for behavioral prescribing	Not covered
Government programs	No coverage for any service or supply furnished by, or covered as a benefit under, a program of any government (or its subdivisions or agencies) except for the following: ▪ A program established for its civilian employees ▪ Medicare (Title XVIII of the Social Security Act) ▪ Medicaid (any state medical assistance program under Title XIX of the Social Security Act) ▪ A program of hospice care
Group therapies	There is no coverage for: ▪ Group chiropractic care ▪ Group occupational therapy ▪ Group physical therapy
H	
Hearing aids	▪ Over-the-counter (OTC) hearing aids are not covered ▪ Hearing aid batteries are not covered
Herbal medicine	Not covered
Home modifications or environmental controls	No coverage for items intended for environmental control or home modification such as bathroom items, electronic door openers, air cleaners, dehumidifiers, elevators, ramps, and stairway lifts
Homemaking services	Not covered
Homeopathic / holistic / naturopathic care	Not covered
Household residents	No coverage for services received from anyone who shares your legal residence
Hypnotherapy	Not covered
I	
Immunization titers	Covered for pregnant women only **Immunization titers** are lab tests performed to determine if a person has had a vaccination.
Incontinence supplies	Not covered

Service	What is not covered or has limited coverage
Infertility treatment	▪ 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 covered only when provided as part of gender affirmation (reassignment) services, and are limited to a maximum of 12 months in storage. ▪ The Plan does not pay people to be surrogates (gestational carriers) for UniCare plan members, and there is no coverage for medical services, including in vitro fertilization, for a surrogate who is not a UniCare member.
Intraocular lenses (IOLs)	Monofocal intraocular lenses (IOLs) are covered when implanted in the eye after the removal of cataracts. Presbyopia-correcting IOLs, which restore vision in a range of distances, are not covered. Multifocal IOLs and accommodating IOLs are presbyopia-correcting IOLs and are also not covered.
L	
Lift / riser chairs	Not covered
Light boxes	Covered only for treatment of skin conditions
Long-term maintenance care and long-term therapy	Not covered
M	
Massage therapy	No coverage for massage therapy or any other services from a massage therapist or neuromuscular therapist
Medical necessity	There is no coverage for any treatment that is not medically necessary. The only exceptions to this requirement are: ▪ Routine care of a newborn child provided by a hospital during a hospital stay that starts with birth and while the child's mother is confined in the same hospital ▪ Covered preventive care provided by a hospital or doctor (Chapter 6) ▪ A service or supply that qualifies as covered hospice care (pages 50-51)

Service	What is not covered or has limited coverage
Medical orders	There is no coverage for any service or supply that has not been recommended and approved by a physician. All covered services and supplies need a medical order from a physician.
Military service or wartime injuries	No coverage for services to treat a condition that was the result of war (declared or undeclared), or service in the armed forces of any country if you are legally entitled to other benefits (such as through the Veterans Administration)
Missed appointments	Not covered
N	
Narconon treatment and facilities	Not covered
Non-conventional behavioral health treatments	No coverage for non-conventional behavioral health treatments. Examples of non-conventional treatments include: ▪ Aversive or counter-conditioning ▪ Brain imaging or mapping to diagnose behavioral health disorders ▪ Hemodialysis ▪ Olfactory/gustatory release ▪ Primal therapy ▪ Prometa (GABASYNC) treatment protocol ▪ Rolfing ▪ Structural Integration
Non-conventional treatment settings	No coverage for treatment performed in a non-conventional setting. Examples of non-conventional settings include: ▪ Spas or resorts ▪ Therapeutic or residential schools ▪ Educational, vocational, or recreational locations ▪ Day care or preschools ▪ Outward Bound ▪ Wilderness, camp or ranch programs
Non-covered services and associated services	Non-covered services include those for which there is no benefit and those that the Plan has determined to be not medically necessary. If a service is not covered by the Plan, any associated services are also not covered. For example, anesthesia and facility fees associated with a non-covered surgery are not covered.

Service	What is not covered or has limited coverage
Nutritional counseling	Services or counseling (therapy) must be performed by a registered dietician and are only covered for: ▪ Adults who are overweight or obese and who are at high risk for cardiovascular disease (limited to three visits a year) ▪ Children who are overweight or obese (Chapter 6) ▪ Children under 18 with cleft lip/palate (page 34) ▪ Members with certain eating disorders ▪ Members with diabetes (page 38)
Nutritional supplements (oral)	No coverage for nutritional supplements administered by mouth, including: ▪ Dietary and food supplements that are administered orally, and related supplies ▪ Nutritional supplements to boost caloric or protein intake, including sport shakes, puddings and electrolyte supplements
O	
Occupational therapy	No coverage for group occupational therapy
Orthodontic treatment	Not covered
Orthopedic mattresses	Not covered
Orthotics	No coverage for temporary or trial orthotics, video tape gait analysis, diagnostic scanning, or arch supports
Oxygen equipment for travel	No coverage for oxygen equipment required for use on an airplane or other means of travel
P	
Park admissions	No coverage for admissions fees to national parks or preserves
Pastoral counselors	Covered for bereavement counseling, or when required by law
Personal items	No coverage for personal items that could be purchased without a prescription (e.g., air conditioners, arch supports, bed pans, bathroom items, blood pressure cuffs, commodes, computer-assisted communications devices, corrective shoes, heating pads, hot water bottles, incontinence supplies, lift or riser chairs, non-hospital beds, orthopedic mattresses, shower chairs, telephones, televisions, thermal therapy devices, whirlpools)

Service	What is not covered or has limited coverage
Physical therapy	▪ No coverage for certain therapy services including, but not limited to: acupuncture, aerobic exercise, craniosacral therapy, diathermy, infrared therapy, kinetic therapy, microwave therapy, paraffin treatment, Rolfing therapy, Shiatsu, sports conditioning, ultraviolet therapy, and weight training. ▪ No coverage for group physical therapy
Private duty nursing	Not covered
Programs with multiple services	No coverage for programs that provide multiple services but that bill at a single, non-itemized rate (for example, a daily fee for a full-day rehab program). Itemized bills are always required.
Providers	▪ No coverage for services from providers who have been sanctioned ▪ No coverage for services from unlicensed providers ▪ No coverage for services outside the scope of a provider's license
R	
Reiki therapy	Not covered Reiki is a hands-on energy-based therapy.
Religious facilities	No coverage for services received at non-medical religious facilities
Residential treatment for behavioral health services	No coverage for non-acute residential treatment. Examples of such treatment include: ▪ Clinically-managed, low-intensity residential services ▪ Clinically-managed, population-specific, high-intensity residential services ▪ Recovery residences ▪ Sober homes
Respite care	Limited to a total of five days each calendar year. Respite care is covered in a hospital, a skilled nursing facility, a nursing home or in the home.
Routine screenings	No coverage except according to the preventive care schedule (Chapter 6)
S	
School services	No coverage for services provided through schools
Sensory integration therapy	Not covered

Service	What is not covered or has limited coverage
Shipping costs	No coverage for shipping costs, such as the cost of shipping eggs or sperm between fertility clinics
Shoes	No coverage for shoes, including special shoes purchased to accommodate orthotics or to wear after foot surgery, except for: ▪ Therapeutic shoes for the prevention of complications associated with diabetes (limited to one pair each year) ▪ Orthopedic shoes that attach directly to a brace
Stairway lifts and stair ramps	Not covered
Stimulators / stimulation treatments	Transcranial magnetic stimulation is covered under your behavioral health benefit. Otherwise, there is no coverage for stimulators or stimulation treatments, including: ▪ Alpha-Stim cranial electrotherapy stimulator ▪ Fischer Wallace neurostimulators ▪ Vagus nerve stimulation
Storage for blood / bodily fluids	No coverage for the storage of autologous blood donations or other bodily fluids or specimens, except when done in conjunction with a scheduled covered procedure
Surface electromyography (SEMG)	Not covered
T	
Therapy (behavioral health)	▪ Group therapy sessions must be 50 minutes or less ▪ Family and individual therapy must be conducted in a provider's office, a facility or, if appropriate, at a member's home
Thermal therapy	No coverage for any type of thermal therapy, including the application or purchasing of hot packs, cold packs or continuous thermal therapy devices
Third parties	No coverage for any medical supply or service (such as a court-ordered test or an insurance physical) that is required by a third party but is not otherwise medically necessary. Other examples of a third party are an employer, an insurance company, a school, a court or a sober living facility.
TMJ (temporomandibular joint) disorder	Treatment of TMJ disorder is limited to the initial diagnostic examination, initial testing and medically necessary surgery. **TMJ disorder** is a syndrome or dysfunction of the joint between the jawbone and skull and the muscles, nerves and other tissues related to that joint.

Service	What is not covered or has limited coverage
Tobacco cessation counseling	Limited to 300 minutes each calendar year
Transportation to/from appointments	Transportation to the place where you will be receiving hospice services is covered. There is no coverage for any other transportation to or from scheduled appointments.
Travel time	No coverage for travel time to or from medical appointments
V	
Vision correction	No coverage for surgery to correct refractive errors (visual acuity problems). Non-covered services include orthoptics for vision correction, radial keratotomy, and other laser surgeries. Refractive errors include astigmatism, myopia (near-sightedness), hyperopia (far-sightedness), and presbyopia (aging-related blurry vision).
W	
Weight loss	▪ Physician services for weight loss treatment are limited to members whose body mass index (BMI) is 40 or more while under the care of a physician. Any such treatment is subject to periodic review. ▪ No coverage for residential inpatient weight loss programs ▪ No coverage for membership fees and food items used to participate in a commercial weight loss program
Wheelchair transit systems	No coverage for transit systems used to secure wheelchairs in moving vehicles.
Wigs	Not covered for any purpose other than the replacement of hair loss resulting from treatment of any form of cancer or leukemia
Worker's compensation	No coverage for any service or supply furnished for an occupational injury or disease for which a person is entitled to benefits under a workers' compensation law or similar law. **Occupational injury or disease** is an injury or disease that arises out of and in the course of employment for wage or profit.
Worksite evaluations	No coverage for exams performed by a physical therapist to evaluate a member's ability to return to work
X	
X-ray equipment (portable)	No coverage for costs associated with transporting and setting up portable X-ray equipment.

Chapter 11: About your plan and coverage

Types of healthcare providers

What is a healthcare provider? A healthcare provider is a person, place, or organization that delivers healthcare services or supplies. A provider can be a **person** (like a doctor), a **place** (like a hospital), or an **organization** (like a hospice).

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

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 healthcare 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.

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.

Behavioral health providers

Behavioral health providers are providers that treat mental health and substance use disorders. These providers include many types of doctors and therapists, as well as hospitals and other facilities that offer behavioral health treatment.

Behavioral health providers who belong to the Carelon Behavioral Health network are covered at a higher benefit level than providers who don't belong to the Carelon network. For more information about behavioral health providers and the Carelon provider network, see page 74.

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 54-55 for coverage details.

Table 14. Types of inpatient facilities

Inpatient facility	What this type of facility provides
Acute care hospitals	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	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	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

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 42-43 for coverage details.

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.

Table 15. Types of walk-in clinics

Walk-in clinic	What this type of clinic provides
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	Located in retail stores or pharmacies. They offer basic services like vaccinations and treatment for colds or mild sinus infections.
Urgent care centers	Independent, freestanding 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.

Medicare participating providers

Participating providers are healthcare providers who have signed an agreement with Medicare to accept Medicare assignment; that is, they agree to accept Medicare's payment as payment in full for covered services. No matter where you live, participating providers will not balance bill you for charges over the allowed amount. See "How the providers you use can affect your costs" on page 22 to find out more.

Look for Medicare participating providers at medicare.gov.

UniCare preferred and non-preferred vendors

If there aren't any Medicare suppliers for the equipment or supply you need, there may be a UniCare preferred vendor you can use. UniCare **preferred vendors** have contracted with UniCare to accept the Plan's allowed amounts. This means that you won't be balance billed as long as you use preferred vendors for the following services:

- ❑ Durable medical equipment (DME)
- ❑ Medical/diabetic supplies
- ❑ Home health care
- ❑ Home infusion therapy (including enteral therapy)

Services from preferred vendors are covered at 100% of the allowed amount. **Non-preferred vendors** are covered at 80%, so you'll owe 20% coinsurance. Outside of Massachusetts, non-preferred vendors can balance bill you for charges over the allowed amount. Since the Plan doesn't cover balance bills, payment is your responsibility.

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

Find a list of UniCare preferred vendors at unicaremass.com.

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.

How to find providers

To find Medicare participating providers and suppliers, go to medicare.gov.

From the unicaremass.com website, you can look for:

- ❑ Behavioral health providers in the Carelon Behavioral Health network
- ❑ UniCare preferred vendors
- ❑ Other kinds of facilities in Massachusetts, like urgent care centers and ambulatory surgery centers

How UniCare reimburses providers

UniCare reimburses providers on a fee-for-service basis. UniCare does not withhold portions of benefit payments from providers or offer providers incentive payments to control the use of services. Explanations of provider payments are detailed in your *Explanations of Benefits* (EOB). In this Plan, providers may discuss the nature of the way they are compensated with you.

How claims are processed

Before UniCare can process your claims, your claims must first be submitted to Medicare for consideration. Most hospitals, physicians or other healthcare providers will submit claims to Medicare for you. Medicare will send you an *Explanation of Medicare Benefits* (EOMB) that explains what Medicare paid and if any balance remains.

Once Medicare processes your claims, any remaining balance is automatically sent to UniCare Member Services, where benefits under the Medicare Extension plan are determined. This process is called **Medicare crossover**. You are not responsible for paying any balances until the Medicare crossover process is completed. At that time, you will receive an *Explanation of Benefits* (EOB) from UniCare.

How to submit a claim

If you need to submit your own claim, you must first submit your claim to Medicare. You must then submit written proof of the claim to UniCare, with the information listed below.

You must provide this information when you submit a claim:

- Medicare EOMB
- 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.

Download claim forms and other materials from unicaremass.com.

Claims for prescription drug services – These claims must be submitted directly to the administrator of those services. See Part 5 of this handbook (pages 137-144).

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.

Recovery of overpaid claims

If the Plan issues an overpayment for a claim, the Plan has the right to recover the overpayment from one or more of the following:

- ❑ The individual that received the payment or for whom the payment was made
- ❑ Other insurance companies
- ❑ Other organizations

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.

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 will be performed at no cost to you.

Deadlines on bringing legal action

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

Right of reimbursement (payment from a third party)

If you or your dependents get payments from a third party for an injury or disease that UniCare previously paid claims for, UniCare will have a lien on any money you receive. This lien applies to any money you or your covered dependents get from, among others, the person or entity responsible for the injury or disease, his or her insurers, or your own auto insurance carrier, including uninsured or underinsured motorist coverage.

You and your dependents will not have to reimburse UniCare for any more than the amount UniCare paid in benefits.

You or your dependents must execute and deliver any documents required by UniCare or its designee, and do whatever is necessary to help UniCare attempt to recover benefits it paid on behalf of you or your dependents.

For additional information about the right of reimbursement, also called subrogation, see page 163.

About your privacy rights

The GIC's *Notice of Privacy Practices* appears in Appendix A. This notice describes how medical information about you may be used and disclosed, as well as how you can get access to this information. The notice also explains your rights as well as the GIC's legal duties and privacy practices.

About the review process

UniCare reviews certain services to make sure they are eligible for benefits. These **preapproval reviews** – sometimes called **pre-service reviews** or **preauthorizations** – are a standard practice for most health plans. These reviews help ensure that benefits are paid for services that meet the Plan's definition of medical necessity.

> **Note:** The clinical criteria used for these reviews are developed with input from actively practicing physicians, and in accordance with the standards adopted by the national accreditation organizations. The criteria are regularly updated as new treatments, applications and technologies become generally-accepted professional medical practice.

In most cases, your provider will contact UniCare when a service requires review. Callers can leave a message if calling after business hours; Member Services will return the call on the next business day. When calling, UniCare staff will identify themselves by name, title and organization.

Associates, consultants, and other providers are not rewarded or offered money or incentives for denying care or a service, or for supporting decisions that result in using fewer services. UniCare doesn't make decisions about hiring, promoting or firing these individuals based on the idea they will deny benefits. Decisions are based only on appropriateness of care and service and existence of coverage.

When a preapproval is first requested

When UniCare is notified 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.

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.

When you need additional approval

Some medical services may be ongoing and need to be reviewed again at a later time. For example, if you are in the hospital, your doctor may recommend that you stay in the hospital beyond the number of days that the Plan first approved. When this happens, UniCare reviews the additional services just as it did when you were first approved.

About your appeal rights

You have the right to appeal an adverse benefit determination within 180 days of being notified of the determination. Your appeal should state why you believe the final determination was in conflict with the Plan provisions. You should also include all supporting documentation that you or your healthcare provider believes supports your position.

UniCare will review the documentation that you submit, and will make a decision within 30 days after receiving your appeal request. This decision will be sent to you in writing and will include the specific reasons for the decision. The decision notice will also give you instructions for additional appeal procedures, if they are available.

All appeals should be directed to:

UniCare State Indemnity Plan
Appeals Review
P.O. Box 2011
Andover, MA 01810-0035

Chapter 12: About enrollment and membership

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

Free or low-cost health coverage for children and families

If you are eligible for health coverage from your employer but are unable to afford the premiums, your state may have a premium assistance program to help pay for coverage. For more information, see Appendix C, “Mandates and required member notices.”

Application for coverage

You or your dependents must be enrolled in Medicare Parts A and B to be eligible to join the Medicare Extension plan. If you have a dependent who is not covered by Medicare, he or she may enroll in one of the GIC’s non-Medicare plans.

You must apply to the GIC for enrollment in the Plan.

You must enroll dependents when they become eligible, generally within 60 days of the qualifying event (e.g., marriage, birth, adoption). You must complete an enrollment form to enroll or add dependents and supply any required documentation required by the GIC.

Visit www.mass.gov/mygiclink-member-benefits-portal for enrollment instructions. Questions? Retirees can contact the GIC at www.mass.gov/forms/contact-the-gic or by calling 617-727-2310.

When coverage begins

Coverage under the Plan starts as follows:

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 new retirees/Medicare enrollees and 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 impaired by age 19, marries
6. The date the covered divorced spouse remarries (or the date the enrollee remarries)
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 dependent(s) as a new hire, your spouse or dependent(s) may only be enrolled within 60 days of a qualifying event or during the GIC's spring annual enrollment. Visit www.mass.gov/mygiclink-member-benefits-portal for enrollment instructions and www.mass.gov/service-details/gic-qualifying-events to learn more about qualifying events. Questions? Retirees can contact the GIC at www.mass.gov/forms/contact-the-gic or by calling 617-727-2310.

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 www.mass.gov/GIC.

Continuing health coverage for survivors

Surviving spouses of covered 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 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 Group Insurance Commission's (GIC's) health plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA continuation 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 556, Randolph, MA 02368 or by hand delivery to the GIC, 1 Ashburton Place, Suite 1619. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

What is COBRA continuation coverage?

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 continuation coverage ("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.

This notice explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617-727-2310 or write to the Unit at P.O. Box 556, Randolph, MA 02368. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at www.dol.gov/ebsa for more general information about COBRA.

Who is eligible for COBRA continuation 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
- ❑ Your spouse's hours of employment with the Commonwealth or participating municipality 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);
- ❑ The employee-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 continuation 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 event listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA continuation coverage due to employment termination or reduction in hours, your family members' COBRA continuation 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.** For more information about extending the length of COBRA continuation coverage, visit https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf.

COBRA continuation 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 continuation 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 continuation 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) even if the plan generally does not accept late enrollees, if you request enrollment within 30 days after your GIC coverage ends. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you. **Your special enrollment period will end 60 days from the loss of GIC insurance coverage and you may be unable to enroll in other plans; therefore, you should take action right away.**

How much does COBRA continuation 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 continuation 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. You may choose to submit the first payment with your application. If not, you will be billed.**

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, you may purchase health insurance through the Commonwealth's Health Connector Authority, or through the Health Insurance Marketplace in other states (see www.HealthCare.gov or call 800-318-2596). In the Marketplace or Connector, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. The GIC has no involvement in conversion programs, and only very limited involvement in the 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. If you end COBRA coverage early or choose other coverage instead of COBRA, you cannot later switch to COBRA coverage. The Massachusetts Health Connector's website is: https://www.mahealthconnector.org. Also, you may be able to determine if you or your dependents qualify for MassHealth through the Connector's website.

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage. If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage. You may want to think about the following when considering different options: What will each premium cost? What are the provider networks and is my doctor in network? What is on the drug formulary for each plan and will my medications be covered? What is the service area of each plan? What will my cost-sharing obligations be? You should consider what your copays, coinsurance, deductibles, and other amounts will be under each plan.

Your COBRA continuation 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 continuation 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 556, Randolph, MA 02368.***

If you have questions about COBRA continuation coverage, contact the GIC's Public Information Unit at 617-727-2310, or write to the Unit at P.O. Box 556, Randolph, MA 02368. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's 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 **www.healthcare.gov** or, in Massachusetts, visit **www.mahealthconnector.org**.

Coordinating benefits with other health plans (COB)

It is common for family members to be covered by more than one healthcare 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 healthcare 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: Medicare and Medicare Extension

The benefits for an enrollee and his or her dependents simultaneously covered by the UniCare State Indemnity Plan/Medicare Extension 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.

Note that some providers choose not to participate in the Medicare program. If members use these providers for services that Medicare normally covers, the UniCare State Indemnity Plan will only consider for payment the amount that would have been allowed if Medicare had processed the claim as the primary carrier.

> **Example** – Some providers choose not to participate in the Medicare program (that is, they are private contract providers). If you use a private contract provider for services that Medicare normally covers, and the charge is $100, the UniCare State Indemnity Plan subtracts the primary plan's benefit before it pays its portion of the bill. In this case, the Plan assumes that Medicare would have paid $80, leaving $20 in coinsurance. The Plan will apply its benefit to the $20, and you may be responsible for the remainder.

Determining the order of coverage: non-Medicare plans

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 healthcare 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

Chapter 13: Other plan resources

Getting help from UniCare Member Services

To reach UniCare Member Services, 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 124).

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

- ❑ Claim status
- ❑ Preapproval reviews
- ❑ Covered services
- ❑ UniCare preferred vendors and Medicare suppliers
- ❑ Plan benefits
- ❑ Resources on the unicaremass.com website

Clinical services include registered nurses and other healthcare professionals who can provide assistance with complex medical issues. Clinical services can help you:

- ❑ Review your ongoing needs
- ❑ Find out about other services that may be useful
- ❑ Get information about your Medicare benefits
- ❑ Guide you on home care plans, as appropriate

How to reach UniCare Member Services

	Contact	Hours (Eastern time)
By phone	800-442-9300 TTY: 711 (toll free)	7:30 a.m. to 6:00 p.m. (M-Th) 7:30 a.m. to 5:00 p.m. (F)
Send an email	contact.us@anthem.com	Anytime

About the Sydney Health app

The **Sydney Health** app gives you electronic access to plan information and member services from your mobile device. Download Sydney Health to your mobile device from the App Store® or Google Play®. Once you've registered as a UniCare member, Sydney Health has tools that let you track not just your claims but your overall health and medical situation.

Use the Sydney Health app to…

- Get information about your plan benefits
- Check on the status of your claims
- Look for healthcare providers
- Keep track of your member costs
- Get your electronic member ID card
- Get suggestions and tips for managing health conditions like diabetes or asthma
- Sync with a FitBit or other fitness tracker
- Get digital reminders about scheduling checkups and important tests

In this handbook, the smartphone symbol lets you know about information you can find, tasks you can perform, and resources that are available through the Sydney Health app.

You can also access Sydney Health online by logging in at unicaremass.com. See below for instructions on how to register for your UniCare account, if you haven't already done so.

About unicaremass.com

You can find additional information and resources at the unicaremass.com website. From the website, you can:

- ❑ **Check on your claims and other account information** – You'll need to register as a UniCare member (if you haven't already registered through the Sydney Health app). Once you're registered, you can check your account anytime.

  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.

- ❑ **Download forms, fliers, and other materials, including this handbook** – We recommend using your handbook as a PDF because it is almost always easier and faster to find information by searching in a PDF.

- ❑ **Look for healthcare providers such as:**
  - Behavioral health providers in the Carelon Behavioral Health network
  - UniCare preferred vendors
  - Other kinds of facilities in Massachusetts, like urgent care centers and ambulatory surgery centers

Throughout this handbook, the **computer** lets you know about information you can find, tasks you can perform, and resources that are available through unicaremass.com.

Calling the 24-Hour Nurse Line

The **24-Hour Nurse Line** provides toll-free access to extensive health information at any time. The Nurse Line 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-Hour Nurse Line, 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 Nurse Line can also refer you to local, state and national self-help agencies.

To speak with a nurse, call the Nurse Line toll free at 800-424-8814 and, when prompted, be sure to choose the Nurse Line option.

How to ask for a claim review

If you have questions about a claim, you can ask UniCare to review the claim. Contact us in any of the ways listed below. Be sure to provide us with any additional information about your claim, if any. We will notify you of the result of the investigation and the final determination.

- ❑ **Call** UniCare Member Services at 800-442-9300
- ❑ **Email** UniCare Member Services at contact.us@anthem.com
- ❑ **Mail** your written request to:

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

How to 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.

Download the *Member Authorization Form* from unicaremass.com

The GIC's policies for releasing and requesting medical information to a third party comply with the Health Insurance Portability and Accountability Act (HIPAA). For more details, see the GIC's *Notice of Privacy Practices* in Appendix A.

Chapter 14: Plan definitions

Term	What it means…
A	
Acupuncture withdrawal management (detox)	The use of acupuncture to ease the symptoms of drug or alcohol withdrawal.
Acute residential treatment	Short-term, 24-hour programs that provide behavioral health treatment within a protected and structured environment.
Acute residential withdrawal management	Drug or alcohol withdrawal (detox) that is medically monitored, for members at risk of severe withdrawal.
Adverse benefit determination *(page 109)*	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, healthcare 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 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 coinsurance and copays ▪ A rescission of coverage (a retroactive cancellation), except if it results from failure to pay premiums
Allowed amount *(page 21)*	The maximum amount on which payment is based for covered healthcare services. For services covered by Medicare, the allowed amount is the same as the Medicare-approved amount. For services not covered by Medicare, the allowed amount is the amount UniCare determines to be within the range of payments most often made to similar providers for the same service or supply. This allowed amount may not be the same as the provider's actual charge.

Term	What it means…
Ambulatory surgery center	An independent, freestanding facility licensed to provide same-day medical services that require dedicated operating rooms and post-operative recovery rooms. These facilities are independent centers, not hospital-run facilities located in a hospital or elsewhere. The presence of a hospital name indicates that the site is a hospital facility, not an ambulatory surgery center.
Ambulatory withdrawal management	Drug or alcohol withdrawal process in which a member has daily visits with a provider throughout withdrawal. More commonly called **outpatient detox**.
Appeal *(page 110)*	A request that UniCare review an adverse benefit determination or a grievance.
Applied Behavior Analysis (ABA)	Specialized therapy used to treat autism spectrum disorders that focuses on improving appropriate behaviors and minimizing negative behaviors.
B	
Balance billing *(page 21)*	When a provider bills you for the difference between what the provider billed and the amount paid by the Plan (the allowed amount). For example, if the provider's charge is $100 and the allowed amount is $70, the provider may balance bill you for the remaining $30.
Behavioral health services *(pages 73-88)*	Services to treat mental health and substance use disorder conditions. The benefits for these services are described in Part 3 of this handbook.
C	
Clinical stabilization services (CSS)	Clinically managed detox and recovery services provided in a non-medical setting.
Coinsurance *(page 20)*	Your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance *plus* any copays that may apply.
Coinsurance limit	See **Out-of-pocket (OOP) maximums**
Community-based acute treatment (CBAT)	Treatment for children and adolescents with serious behavioral health disorders who need a protected and structured environment.
Community support programs (CSP)	Programs to help members access and use behavioral health services.
Copay (copayment) *(page 20)*	A fixed amount you pay for a covered healthcare 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.

Term	What it means…
Cosmetic services *(page 92)*	Services performed mainly to improve appearance. These services do not restore bodily function or correct functional impairment. Cosmetic services are not covered.
Cost sharing *(Chapter 2)*	Your share of the cost for a covered service that you must pay out of your own pocket. Your share can be a copay and/or coinsurance.
Crisis stabilization unit (CSU)	24-hour observation and supervision for behavioral health conditions when inpatient care isn't needed.
Custodial care *(page 93)*	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.
D	
Day treatment	Behavioral health programs offering structured, goal-oriented treatment that focuses on improving one's ability to function in the community.
Dependent *(Chapter 12)*	1. The employee's or retiree's spouse or a divorced spouse who is eligible for dependent coverage pursuant to Massachusetts General Laws Chapter 32A as amended 2. A GIC-eligible child, stepchild, adoptive child or eligible foster child of the member, or of the member's spouse, until the end of the month following the dependent's 26th birthday 3. A GIC-eligible unmarried child who upon becoming 19 years of age is mentally or physically incapable of earning his or her own living, proof of which must be on file with the GIC 4. A dependent of a dependent, if the primary dependent is either a full-time student or an IRS dependent, or has been an IRS dependent within the past two years If you have questions about coverage for someone whose relationship to you is not listed above, contact the GIC.
Dialectical behavioral therapy (DBT)	A combination of behavioral, cognitive and supportive therapies designed to help change unhealthy behaviors and treat people suffering from behavioral health disorders.
DME (durable medical equipment)	Equipment and supplies ordered by a healthcare provider for everyday or extended use. Oxygen equipment, wheelchairs, and crutches are all examples of DME.
DPH-licensed providers	The Massachusetts Department of Public Health (DPH) issues licenses to Massachusetts facilities that provide healthcare services. To be licensed, facilities must meet specific quality and safety standards.

Term	What it means…
Dual diagnosis acute treatment (DDAT)	Clinically-managed detox and recovery services for those with both a substance use and mental health condition who require a protected and structured environment.
E	
Elective	A medical service or procedure is elective if you can schedule it in advance, choose where to have it done, or both.
Electroconvulsive therapy (ECT)	Psychiatric treatment in which seizures are electrically induced to provide relief from mental disorders.
Emergency	An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: ▪ Your health would be put in serious danger, or ▪ You would have serious problems with your bodily functions, or ▪ You would have serious damage to any part or organ of your body.
Emergency service program (ESP)	Programs that provide behavioral health crisis assessment, intervention and stabilization services on short notice.
Enrollee	An employee, retiree or survivor who is covered by the GIC's health benefits program and enrolled in the UniCare State Indemnity Plan. (Enrollees are the same as subscribers.)
Excluded services	Healthcare services that the Plan doesn't pay for or cover.
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.
F	
Family stabilization team (FST)	Programs offering intensive services in the home to help children, adolescents and their families deal with complex life stressors.
H	
Healthcare provider	A person, place, or organization that delivers healthcare services or supplies. A provider can be a **person** (like a doctor), a **place** (like a hospital), or an **organization** (like hospice).
Healthcare services	In this handbook, we use "healthcare services" when we're talking about both medical and behavioral health services.

Term	What it means…
High-tech imaging	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.
Home state	The state where you live and get your routine health care.
Hospital / acute care hospital *(pages 54-55)*	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
I	
Injury	Accidental bodily harm caused by something external (outside of your body).
Inpatient behavioral health services *(pages 82-84)*	Treatment for behavioral health conditions that have severe symptoms but that are expected to improve with intensive, short-term treatment.
Inpatient medical care *(pages 54-55)*	Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Inpatient hospital services may also be referred to as **hospitalization**.
Intensive outpatient program (IOP)	Programs that offer thorough, regularly-scheduled behavioral health treatment in a structured environment. These programs offer at least three hours of therapy a day, up to seven days a week.
L	
Long-term care facilities *(pages 54-55)*	Specialized hospitals that treat patients who need further care for complex medical conditions but no longer require the services of a traditional hospital.
M	
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.

Term	What it means…
Medical services	In this handbook, medical services are services to treat medical (physical) conditions – in contrast to **Behavioral health services**.
Medical necessity	With respect to care under the Plan, medical necessity means that 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.
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.
Medication-assisted treatment (MAT) *(page 84)*	Long-term prescribing of medication as an alternative to the opioid on which a member was dependent. Typically, a member goes to a clinic daily to get the medication.
Medication management	Visits with a behavioral health provider who can evaluate and prescribe medication, if needed.
Member	An enrollee or his/her dependent who is covered by the Plan.
Member costs *(Chapter 2)*	Costs that you pay yourself toward your medical bills: copays and coinsurance. Member costs are also known as **out-of-pocket costs**.
N	
Network	The facilities, providers and suppliers that the Plan has contracted with to provide healthcare services.
Neuropsychological (neuropsych) testing	Testing to find out if a problem with the brain is affecting one's ability to reason, concentrate, solve problems, or remember.

Term	What it means…
Non-hospital-owned facility	Facilities that perform outpatient medical services but that are not owned by or operated by a hospital. Non-hospital-owned facilities include many ambulatory surgery centers and urgent care centers.
Non-preferred vendor *(page 23)*	A vendor who is neither Medicare nor UniCare-contracted to provide certain services or equipment including, but not limited to, durable medical equipment and medical supplies. In some cases, you will have no coverage when you use a non-preferred vendor.
O	
Observation care	A well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made about whether a patient will need inpatient hospital treatment or if he or she can be discharged from the hospital. Observation care is considered outpatient and is usually provided in medical centers and community hospitals.
Office services *(pages 85-86)*	Behavioral health services that can be provided in an office or office-like setting
Opiate treatment programs (OTP)	Programs licensed to distribute and administer medications as an alternative to an opioid on which a member was dependent.
Out-of-pocket costs	See **Member costs**
Out-of-pocket (OOP) maximums *(page 19)*	The most you could pay during a calendar year for member costs (copays and coinsurance) for covered services. Once you reach an out-of-pocket maximum, the Plan starts to pay 100% of the allowed amount. There are three separate out-of-pocket maximums, each of which applies to different services: ▪ Coinsurance limit ▪ Out-of-pocket maximum for in-network behavioral health costs ▪ Out-of-pocket maximum for out-of-network behavioral health costs Out-of-pocket maximums don't include prescription drug costs, premiums, balance bills, or costs for services that the Plan doesn't cover.
Outpatient behavioral health services *(pages 86-87)*	Services that don't require an inpatient hospital admission or overnight stay. Outpatient services include office services as well as more intensive types of behavioral health treatment.
Outpatient hospital services	Care at a hospital that doesn't require being admitted to the hospital. Outpatient care usually doesn't include an overnight stay. **Outpatient services** sometimes means health care provided at any non-hospital facility, such as a doctor's office or walk-in clinic.

Term	What it means…
P	
Palliative care	Medical care that focuses on treating symptoms – like severe pain, or plan difficulty breathing – to make you more comfortable. Palliative care is not intended to cure underlying conditions.
Partial hospitalization programs (PHP)	Non-residential, structured outpatient psychiatric and substance use programs that are more intensive than one would get in a doctor's office, but that are an alternative to inpatient care. These programs offer at least five hours of therapy a day, up to seven days a week.
Physician	Includes the following healthcare providers acting within the scope of their licenses or certifications: ▪ Certified nurse midwife ▪ Chiropractor ▪ Dentist ▪ Nurse practitioner ▪ Optometrist ▪ Physician ▪ Physician assistant ▪ Podiatrist See page 74 for a list of types of behavioral health providers.
Preapproval	Review process to confirm that a service you're going to have is eligible for benefits. Preapproval review lets you make sure that services you'll be getting are covered under the Plan.
Preferred vendors *(page 23)*	Medicare suppliers or UniCare-contracted vendors who deliver certain services or equipment including, but not limited to, durable medical equipment (DME), medical supplies, and home health care. You get these services at a higher benefit level when you use preferred vendors. When available, Medicare suppliers are the preferred vendors. For services that aren't available from Medicare suppliers – including services that Medicare doesn't cover but are covered by the Plan – the preferred vendors are providers that contract with UniCare.
Provider	See **Healthcare provider**
Psychiatric visiting nurse (VNA) services	Short-term treatment delivered in the home or living environment to treat a behavioral health disorder with medication.
Psychological (psych) testing	Standardized assessment tools to diagnose and assess overall psychological functioning.

Term	What it means…
R	
Rehabilitation (rehab) facilities *(pages 54-55)*	Specialized hospitals that provide rehab services to restore basic functioning (such as walking or sitting upright) that was lost due to illness or injury.
Rehabilitation (rehab) services	Healthcare 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.
Respite care	Services given to an ill patient to relieve the family or primary care person from caregiving functions.
Retail health clinic *(pages 104-105)*	Walk-in clinics located in retail stores or pharmacies. They offer basic services like vaccinations and treatment for colds or mild sinus infections.
S	
Skilled care	Medical services that can only be provided by a registered or certified professional healthcare provider.
Skilled nursing facility *(pages 54-55)*	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.

Term	What it means…
Structured outpatient addictions programs (SOAP)	Non-residential, structured substance use disorder programs that are more intensive than one would get in a doctor's office, but that are an alternative to inpatient care. These programs offer at least three hours of therapy a day, up to seven days a week.
Substance use disorder assessment / referral	A comprehensive assessment of substance use to allow a provider to refer a member to appropriate care.
T	
Transcranial magnetic stimulation (TMS)	A non-invasive method of brain stimulation used to treat major depression.
Transitional care unit (TCU)	Facilities that help children and adolescents transition from an acute care facility to home, a residential program, or foster care.
U	
Urgent care *(pages 42-43)*	Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.
Urgent care center *(pages 104-105)*	An independent, freestanding 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.
V	
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.
W	
Walk-in clinics *(pages 104-105)*	Sites that offer medical care on a walk-in basis, so no appointment is needed. Urgent care centers and retail health clinics are two examples of walk-in clinics.

PART 5:

YOUR PRESCRIPTION DRUG PLAN

Description of benefits for prescription drugs

SilverScript Employer PDP sponsored by the Group Insurance Commission

A Medicare Prescription Drug Plan (PDP) offered by SilverScript®
Insurance Company with a Medicare contract

For questions about any of the information in Part 5 of this handbook, please call SilverScript at 877-876-7214 (TTY: 711).

Administered by

SilverScript®

Chapter 15: Your prescription drug plan

About SilverScript

SilverScript Employer PDP sponsored by the Group Insurance Commission (GIC) is a Medicare-approved Part D prescription drug plan with additional coverage provided by the GIC to expand the Part D benefits. “Employer PDP” means that the plan is an employer-provided prescription drug plan. The plan is offered by SilverScript® Insurance Company, which is affiliated with CVS Caremark®, the GIC’s pharmacy benefit manager.

You are automatically enrolled in SilverScript coverage when you enroll in one of the GIC’s Medicare products. Do not enroll in any other Part D (prescription drug) plan. Doing so will immediately terminate your GIC health and prescription drug coverage.

Plan costs

This section includes information about your monthly premium, annual deductible (if any), and cost-sharing amounts during the Initial Coverage Stage for SilverScript. Although most members do not reach the Coverage Gap Stage (Stage 3) or the Catastrophic Coverage Stage (Stage 4) during the plan year, a summary of your costs in those stages is also included.

Monthly Premium

There is no separate prescription drug premium. This benefit is provided as part of your GIC health plan coverage.

Please note: If your modified adjusted gross income is above a certain amount, you may pay a Part D income-related monthly adjustment amount (Part D IRMAA). Medicare uses the modified adjusted gross income reported on your IRS tax return from two years ago (the most recent tax return information provided to Social Security by the IRS).

If Social Security notifies you about paying a higher amount for your Part D coverage, you’re required by law to pay the Part D income-related monthly adjustment amount (Part D IRMAA). **You pay your Part D IRMAA directly to Medicare, not to your plan or employer.**

You’re required to pay the Part D IRMAA even if your employer or a third party (like a teacher’s union or a retirement system) pays for your Part D plan premiums. If you don’t pay the Part D IRMAA and get disenrolled, you may also lose your retirement coverage and you may not be able to get it back.

For more information about Part D premiums based on income, call Medicare at 800-MEDICARE (800-633-4227).

Medicare Part D Drug Payment Stages

All Medicare Part D prescription drug plans have drug payment stages where drug costs may vary. You move through each stage based on the amount either you or the plan spend on prescription drugs. See the following section for information on the Medicare Part D drug payment stages. The Part D *Explanation of Benefits (EOB)* and other plan materials include additional information on the four drug payment stages.

Stage 1: Deductible Stage

Because you have no deductible, this payment stage does not apply to you.

Stage 2: Initial Coverage State Cost Sharing

During the Initial Coverage Stage, you pay a portion of your drug costs, and the plan pays its portion. The following tables show what you pay until your total yearly drug costs reach $4,660. Total yearly drug costs are the total drug costs paid by both you and SilverScript. You may get your drugs at network retail pharmacies or through the mail-order pharmacy.

Table 16. Summary of Prescription Drug Benefits

2023 SilverScript Summary of Prescription Drug Benefits for the Group Insurance Commission			
Monthly Premium	There is no separate prescription drug premium. This benefit is provided as part of your GIC health plan coverage.		
Deductible	This plan does not have a deductible.		
Your share of the cost when you get a 30-day supply of a covered Part D prescription drug			
	Network Retail Pharmacy (Up to a 30-day supply available at **any** network pharmacy)	**Mail-Order Pharmacy** (Up to a 30-day supply)	**Long-Term Care (LTC) Pharmacy** (Up to a 31-day supply)
Tier 1: Generic	$10	$25	$10
Tier 2: Preferred Brand	$30	$75	$30
Tier 3: Non-Preferred Brand	$65	$165	$65

Your share of the cost when you get a *long-term* supply (up to 90 days) of a covered Part D prescription drug			
	Preferred Network Retail Pharmacy (Up to a 90-day supply)	**Standard Network Retail Pharmacy** (Up to a 90-day supply)	**Mail-Order Pharmacy** (Up to a 90-day supply)
Tier 1: Generic	$25	$30	$25
Tier 2: Preferred Brand	$75	$90	$75
Tier 3: Non-Preferred Brand	$165	$195	$165

Note: You pay the same share of the cost for your drug filled through the Mail-Order Pharmacy, whether you get a one-month supply or a long-term supply. This means that the copay or coinsurance listed in the previous table is applicable for any order, regardless of the day supply.

Please note: If you go to an out-of-network pharmacy, you will be reimbursed the cost of the drug less your cost share.

Stage 3: Coverage Gap Stage Cost Sharing

The coverage gap begins after the total yearly drug costs (including what the plan has paid and what you have paid) reaches $4,660.

Due to the additional coverage provided by the GIC, you have the same copays or coinsurance that you had during the Initial Coverage Stage. Therefore, you may see no change in your copay and/or coinsurance until you qualify for catastrophic coverage.

Stage 4: Catastrophic Coverage State Cost Sharing

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400 you pay 5% of the cost for a covered drug, but not greater than the cost share amounts listed in the Initial Coverage Stage section above.

Who can join?

To join SilverScript, you must be eligible for coverage provided by the GIC, be entitled to Medicare Part A and/or be enrolled in Medicare Part B, be a United States citizen or be lawfully present in the United States, and live in our service area. SilverScript is available in the United States and its territories.

Which drugs are covered?

To find out if your drug is on the formulary (list of Part D prescription drugs) or about any restrictions, call SilverScript Customer Care at 877-876-7214 (TTY: 711). You may also request a copy of the complete plan formulary.

Please note: The GIC provides additional coverage that may cover prescription drugs not included in your Medicare Part D benefit, such as:

- ❑ Prescription drugs for anorexia, weight loss, or weight gain
- ❑ Prescription drugs for the symptomatic relief of cough or cold
- ❑ Prescription vitamins and mineral products not covered by Part D
- ❑ Prescription drugs for treatment of sexual or erectile dysfunction
- ❑ Certain diabetic drugs and supplies not covered by Part D
- ❑ Prescription drugs for tobacco cessation
- ❑ Part B products, such as oral chemotherapy agents

For more information about your share of the cost or which prescription drugs may or may not be covered, please call SilverScript Customer Care at 877-876-7214 (TTY: 711). The SilverScript formularies do not include any drugs that may be available to you through the additional coverage provided by the GIC.

How will I determine my drug costs?

SilverScript groups each medication into one of three tiers. Use your formulary to find out the tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and whether you are in the Deductible (if any), Initial Coverage, Coverage Gap, or Catastrophic Coverage Stage. As you move from stage to stage, the amount you and the plan pay for your drugs may change. If the actual cost of a drug is less than the normal copay or coinsurance for that drug, you will pay the actual cost, not the higher copay or coinsurance.

Which pharmacies can I use?

More than 66,000 pharmacies nationwide make up the pharmacy network. These include retail, mail-order, long-term care and home infusion pharmacies. To find a network pharmacy near your home or where you are traveling in the United States or its territories, call SilverScript Customer Care at 877-876-7214 (TTY: 711) or use our online pharmacy locator tool on gic.silverscript.com.

You generally must use a network pharmacy in order to receive full benefit coverage on your prescriptions. You may get drugs from an out-of-network pharmacy in an emergency, but you may have to pay the full cost (rather than your normal share of the cost) at the time you fill your prescription. If you use an out-of-network pharmacy, we will reimburse you your total cost minus your copay amount for the drug. You must submit a paper claim in order to be reimbursed.

If you need to get your prescription filled while you are traveling outside the country, contact SilverScript Customer Care **before** you leave the U.S. You can request a vacation override for up to a 90-day supply of your medication. If you are traveling outside of the country and have an emergency drug expense, submit your itemized receipt with the completed SilverScript claim form to the GIC at P.O. Box 556, Randolph, MA 02368.

Please note: Veterans Affairs (VA) pharmacies are not permitted to be included in Medicare Part D pharmacy networks. The federal government does not allow you to receive benefits from more than one government program at the same time.

If you are eligible for VA benefits, you may still use VA pharmacies under your VA benefits. However, the cost of those medications and what you pay out-of-pocket will not count toward your Medicare out-of-pocket costs or Medicare total drug costs. Each time you get a prescription filled, you can compare your GIC benefit through SilverScript to your VA benefit to determine the best option for you.

Through the additional coverage provided by the GIC, you may be able to save on your maintenance prescription drugs by changing your 30-day supply to a 90-day supply at any CVS Pharmacy®, Longs Drugs (operated by CVS Pharmacy), or Navarro Discount Pharmacy location. These pharmacies are called "preferred network retail pharmacies."

If you're currently taking any long-term prescription drugs, you can continue to fill your 30-day supplies. However, you may save by changing your 30-day supply to a lower-cost 90-day supply. Filling one 90-day supply may cost you less than three 30-day supplies of the same prescription drug.

You can choose from two 90-day supply options for the same low price:

- **Option 1:** Refill at any CVS Pharmacy, Longs Drugs (operated by CVS Pharmacy), or Navarro Discount Pharmacy location, and pick up your prescription drugs at your convenience.
- **Option 2:** Refill with CVS Caremark Mail Service Pharmacy and have a 90-day supply of your long-term prescription drugs shipped to your home.

For questions about maintenance drugs with additional coverage provided by the GIC, including the cost to fill these drugs, please contact SilverScript Customer Care at 877-876-7214 (TTY: 711).

This document provides a summary of what SilverScript covers and what you will pay. To get a complete list of our benefits, please call SilverScript Customer Care at 877-876-7214 (TTY: 711) and ask for the *Evidence of Coverage*.

If you want to know more about the coverage and costs of original Medicare, look in your current *Medicare & You* handbook. View it online at www.medicare.gov or get a copy by calling 800-MEDICARE (800-633-4227), 24 hours a day, 7 days a week. TTY users should call 877-486-2048.

See *Evidence of Coverage* for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of SilverScript. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

SilverScript's pharmacy network includes limited lower-cost, preferred pharmacies in Alaska; suburban and rural areas of Idaho, Puerto Rico, Washington, and Wyoming; and rural areas of Arkansas, Colorado, Iowa, Kansas, Kentucky, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Mexico, North Dakota, Oklahoma, Oregon, and Wisconsin. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 877-876-7214 (TTY: 711), 24 hours a day, 7 days a week, or consult the online pharmacy directory at gic.silverscript.com.

Members who get "Extra Help" are not required to fill prescriptions at preferred network pharmacies in order to get Low Income Subsidy (LIS) copays.

The typical number of business days after the mail-order pharmacy receives an order to receive your shipment is up to 10 days. Enrollees have the option to sign up for automated mail-order delivery.

SilverScript Employer PDP is a Prescription Drug Plan. This plan is offered by SilverScript Insurance Company, which has a Medicare contract. Enrollment depends on contract renewal.

Important plan information
Información Importante Sobre el Plan

SilverScript Customer Care

Call	1-877-876-7214 Calls to this number are free, 24 hours a day, 7 days a week. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free, 24 hours a day, 7 days a week.
Fax	1-888-472-1129
Write	SilverScript Insurance Company P.O. Box 30016 Pittsburgh, PA 15222-0330

PART 6:

APPENDICES

Notices and reference information

Appendix A: GIC notices

Notice of Group Insurance Commission Privacy Practices

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.

Effective July 1, 2022

By law, the GIC must protect the privacy and security 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 www.mass.gov/GIC.

Required and permitted uses and disclosures

We typically use or share your health information in the following ways.

Run our organization

- ❑ We can use and disclose your information to run our organization and contact you when necessary.
- ❑ To operate our programs that include evaluating the quality of health care services you receive and performing analyses to reduce health care costs and improve our health plans performance.
- ❑ Arrange for legal and auditing services including fraud and abuse protection

Pay for your health services

We can use and disclose your health information as we pay for your health services, administrative fees for health care and determining eligibility for health benefits.

Provide you with information on health-related programs or products

This might be information regarding alternative medical treatments or programs or about other health-related services and products.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- ❑ Preventing disease
- ❑ Helping with product recalls
- ❑ Reporting adverse reactions to medications
- ❑ Preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

- ❑ We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law
- ❑ Address workers' compensation, law enforcement, and other government requests
- ❑ For law enforcement purposes or with a law enforcement official
- ❑ With health oversight agencies for activities authorized by law
- ❑ Respond to lawsuits and legal actions
- ❑ We can share health information about you in response to a court or administrative order, or in response to a subpoena

The GIC may also use and share your health information as follows:

- ❑ To resolve complaints or inquiries made by you or on your behalf (such as an appeal).
- ❑ To enable business associates that perform functions on our behalf or provide services if the information is necessary for such functions or service. 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 notice of unauthorized acquisition, access, or disclosure of your health information.
- ❑ To verify agency and plan performance (such as audit).
- ❑ To communicate with you about your GIC-sponsored benefits (such as your annual benefits statement).
- ❑ To tell you about new or changed benefits and services or health care choices.

Organizations that assist us

In connection with payment and healthcare 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.

When it comes to your health information, you have certain rights

This section explains your rights and some of our responsibilities to help you. You have the right to:

- ❑ **Get a copy of your health and claims records** – You can ask to see or get a copy of your health and claims records and other health information we have about you. 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). We will provide a copy or a summary of your health and claims records. We may charge a reasonable, cost-based fee.
- ❑ **Ask us to correct our records** – You can ask us to correct your health and claims records if you think they are incorrect or incomplete. You must ask for this in writing along with a reason for your request. We may say "no" to your request, but we'll tell you why in writing within 60 days. If we deny your request, you may file a written statement of disagreement to be included with your information for future disclosures.
- ❑ **Request confidential communications** – You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- ❑ **Ask us to limit what we use or share** – You can ask us not to use or share certain health information for payment or our operations, and disclosures to family members or friends. You must ask for this in writing. We are not required to agree to your request, and in some cases federal law does not permit a restriction.
- ❑ **Get a list of those with whom we've shared information** – You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make or was part of a limited data set for research).
- ❑ **Get a copy of this privacy notice** – You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. (An electronic version of this notice is on our website at www.mass.gov/gic)

- **Choose someone to act for you** – If you have given someone power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **Receive notification of any breach or your unsecured PHI**
- **File a complaint if you feel your rights are violated** – You can complain if you feel we have violated your rights by writing to us at: GIC Privacy Officer, P.O. Box 566, Randolph, MA 02368. Filing a complaint or exercising your rights will not affect your GIC benefits. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call 617-727-2310 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's Medicare Extension plan 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 **https://www.dol.gov/agencies/vets/programs/userra**. An interactive online USERRA Advisor can be viewed at **https://webapps.dol.gov/elaws/vets/userra/**. 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.

Appendix B: Forms

This appendix contains the following form:

- ❑ Fitness Reimbursement Form

Download this form and other materials from unicaremass.com. You can also request materials from UniCare Member Services at 800-442-9300.

Fitness Reimbursement Form

See "Fitness reimbursement" on page 46 for details about what is covered under the fitness reimbursement.

What is the fitness reimbursement?

The Plan offers a $100 reimbursement benefit toward a fitness activity. Upon proof of payment, the reimbursement is paid to the Plan enrollee (subscriber).

What types of fitness activities qualify?

Eligible for reimbursement		Not eligible for reimbursement
▪ Boys & Girls Clubs of America ▪ Classes and programs such as yoga, Pilates, and spin (either in-person or online) ▪ Dance classes/studios ▪ Gyms, health clubs, and fitness centers	▪ Martial arts centers ▪ Personal trainers (either in-person and online) ▪ Sports teams ▪ Organizations and leagues designed for fitness activities (e.g., hiking, bowling, etc.)	▪ Annual or day passes (e.g., ski passes) ▪ Dues for beach or country clubs ▪ Fees for one-day events ▪ Personal or home fitness equipment ▪ Spas or spa services

What do I need to do to get reimbursed?

1. Fill out the **Fitness Reimbursement Request** below.
2. Provide **proof of payment** (for example, a copy of your credit card receipt, email confirmation).
3. Send, fax, or email your request and proof of payment to the address shown below the form.

What else should I know?

- We recommend that you **send proof of payment for the entire amount** instead of making several requests for lesser amounts.
- **Write your UniCare member ID number** on all receipts and documents.
- If you have any questions, call UniCare Member Services (**833-663-4176** for Total Choice, PLUS, and Community Choice members or **800-442-9300** for Medicare Extension members).

Fitness Reimbursement Request

Last name	First name	MI	Street address		
UniCare plan ID number	Birth date		City	State	ZIP code

Fitness participant (if different from UniCare enrollee):

Relationship to UniCare enrollee ☐ Self ☐ Spouse ☐ Child ☐ Other (explain):

Name of fitness facility or description of activity	Requested reimbursement amount $

☐ I have engaged in physical activity an average of four or more times per month

By checking the box above and submitting your proof of payment, you verify that you meet all eligibility requirements.	Signature	Date

Send this form and proof of payment to: UniCare Fitness Reimbursement, PO Box 9016, Andover, MA 01810-0916
You can also fax your paperwork to 978-474-5162 or email it to contact.us@anthem.com

Appendix C: Mandates and required member notices

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're 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 programs. If you or your children aren't eligible for Medicaid or CHIP, you won't 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 aren't 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 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, 2023.
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: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/

Phone: 855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program

Website: http://dhcs.ca.gov/hipp

Phone: 916-445-8322

Fax: 916-440-5676

Email: hipp@dhcs.ca.gov

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+: https://hcpf.colorado.gov/child-health-plan-plus

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

Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/

HIBI Customer Service: 855-692-6442

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html

Phone: 877-357-3268

GEORGIA – Medicaid

GA HIPP website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp

Phone: 678-564-1162, press 1

GA CHIPRA website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra

Phone: 678-564-1162, press 2

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: https://www.in.gov/medicaid/
Phone: 800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid website: https://dhs.iowa.gov/ime/members

Medicaid phone: 800-338-8366

Hawki website: http://dhs.iowa.gov/Hawki

Hawki phone: 800-257-8563

HIPP website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp

HIPP phone: 888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/

Phone: 800-792-4884

HIPP phone: 800-766-9012

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx

Phone: 855-459-6328

Email: KIHIPP.PROGRAM@ky.gov

KCHIP website: https://kidshealth.ky.gov/Pages/index.aspx

Phone: 877-524-4718

Kentucky Medicaid website: https://chfs.ky.gov

LOUISIANA – Medicaid

Websites: www.medicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 888-342-6207 (Medicaid hotline) or 855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment website: https://www.mymaineconnection.gov/benefits/s/?language=en_US

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

Private Health Insurance Premium webpage: https://www.maine.gov/dhhs/ofi/applications-forms

Phone: 800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa

Phone: 800-862-4840

TTY: 617-886-8102

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.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

Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov

Phone: 855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid website: http://dhcfp.nv.gov

Medicaid phone: 800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs- services/medicaid/health-insurance-premium-program

Phone: 603-271-5218

Toll-free number for the HIPP program: 800-852-3345, ext. 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://medicaid.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

Websites: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 800-692-7462
CHIP website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP phone: 800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)

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: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP

Websites:
https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid/CHIP phone: 800-432-5924

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/
Phone: 800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Websites: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid phone: 304-558-1700
CHIP toll-free phone: 855-MyWVHIPP (855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800-362-3002

WYOMING – Medicaid

Website:
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

- U.S. Department of Labor
  Employee Benefits Security Administration
  www.dol.gov/agencies/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]

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

1 OMB Control Number 1210-0137 (expires 1/31/2026)

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 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 healthcare 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 healthcare provider.

If the services are not covered by Medicare, you must notify UniCare if your inpatient maternity stay is longer than two days for vaginal delivery or four days for Caesarian. Please call UniCare Member Services at 800-442-9300 if you have questions.

Member rights and responsibilities (Carelon Behavioral Health)

Your behavioral health benefits are administered by UniCare in partnership with Carelon Behavioral Health. Carelon maintains the network of behavioral health providers as well as providing some other administrative services like case management. This section outlines your member rights and responsibilities for services provided by Carelon.

Member rights

Company and provider information

- ❑ You have the right to receive information about Carelon's services, benefits, practitioners, providers, member rights and responsibilities and clinical guidelines.

Respect

- ❑ You have the right to be treated with respect, dignity and privacy regardless of race, gender, veteran status, religion, marital status, national origin, physical disabilities, mental disabilities, age, sexual orientation, or ancestry.
- ❑ You have a right to receive information in a manner and format that is understandable and appropriate. You have the right to oral interpretation services free of charge for any Carelon materials in any language.
- ❑ You have the right to be free from restraint and seclusion as a means of coercion, discipline, convenience, or retaliation.

Member input

- ❑ You have the right to have anyone you choose speak for you in your contacts with Carelon. You have the right to decide who will make medical decisions for you if you cannot make them. You have the right to refuse treatment, to the extent allowed by the law.
- ❑ You have the right to be a part of decisions that are made about plans for your care. You have the right to talk with your provider about the best treatment options for your condition, regardless of the cost of such care, or benefit coverage.
- ❑ You have the right to obtain information regarding your own treatment record with signed consent in a timely manner and have the right to request an amendment or correction be made to your medical records.
- ❑ You have the right to a copy of your rights and responsibilities. You have a right to tell Carelon what you think your rights and responsibilities as a member should be.
- ❑ You have the right to exercise these rights without having your treatment adversely affected in any way.

Complaints

- ❑ You have the right to make complaints (verbally or in writing) about Carelon staff, services or the care given by providers.
- ❑ You have a right to appeal if you disagree with a decision made by Carelon about your care. Carelon administers your appeal rights as stipulated under your benefit plan.

Confidentiality

- ❑ You have the right to have all communication regarding your health information kept confidential by Carelon and UniCare staff and by contracted providers and practitioners, to the extent required by law.

Access to care, services and benefits

- ❑ You have the right to know about covered services, benefits, and decisions about healthcare payment with your plan, and how to seek these services. You have the right to receive timely care consistent with your need for care.

Claims and billing

- ❑ You have the right to know the facts about any charge or bill you receive.

Member responsibilities

- ❑ You have the responsibility to provide information, to the best of your ability, that Carelon or your provider may need to plan your treatment.
- ❑ You have the responsibility to learn about your condition and work with your provider to develop a plan for your care. You have the responsibility to follow the plans and instructions for care you have agreed to with your provider.
- ❑ You are responsible for understanding your benefits, what's covered and what's not covered. You are responsible for understanding that you may be responsible for payment of services you receive that are not included in the covered services list for your coverage type.
- ❑ You have the responsibility to notify the GIC and your provider of changes such as address changes, phone number change, or change in insurance.
- ❑ If required by your benefit, you are responsible for choosing a primary care provider and site for the coordination of all your medical care.
- ❑ You are responsible for contacting your behavioral health provider, if you have one, if you are experiencing a mental health or substance use emergency.

Carelon Behavioral Health's *Member Rights and Responsibilities* is available in both English and Spanish from Carelon's website (www.carelonbehavioralhealth.com). You can also request a copy by calling Carelon at 888-204-5581 (TTY: 711).

Right of reimbursement (subrogation)

These provisions apply when UniCare pays benefits as a result of injuries or illnesses you or your dependent (hereafter "you") sustained and you have a right to a recovery or have received a recovery from any source. A "recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements or court orders characterize, allocate, or designate the money you receive as a recovery, it shall be subject to these provisions. UniCare's rights of subrogation and reimbursement are not subject to application of the made whole or common fund doctrines and UniCare's rights will not be reduced due to your negligence.

Subrogation

UniCare is subrogated to your rights of recovery and has the right to recover payments it makes from any party responsible for compensating you for your illnesses or injuries. UniCare has the right to take whatever legal action it sees fit against such party to recover the benefits it has paid. UniCare's subrogation claim shall be first satisfied before any part of a recovery is applied to your claim, attorney fees, other expenses/costs.

Reimbursement

UniCare has the right to be reimbursed from any recovery you receive in the amount of benefits paid on your behalf. This right of reimbursement will be considered a priority lien by agreement against any recovery. You will not have to reimburse UniCare for any more than the amount UniCare paid in benefits.

Your Duties

You and your legal representative must do whatever is necessary to enable UniCare, or its designee, to exercise its rights and will do nothing to prejudice those rights. You must cooperate with UniCare in the investigation, settlement and protection of its rights.

You agree to promptly notify UniCare of any pursuit of a recovery (filing a lawsuit or otherwise), your retention of a legal representative (if applicable), and the occurrence of a settlement or verdict. You and your legal representative acknowledge that UniCare's lien is automatically created by the terms of this handbook, any recovery will be held in trust, and UniCare shall be immediately repaid from the recovery in the amount of the benefits paid on your behalf.

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We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese
您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese
Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean
귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog
May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian
Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian
Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi
"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

French
Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

Arabic
لك الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

Japanese
お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian
Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòma tou.

Italian
Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish
Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi
ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਹਾਸਲ ਕਰਨ ਦਾ ਿਅਧਕਾਰ ਹੈ। ਬਸ ਆਪਣy ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. 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 in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to 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. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Notes

To find out about...

Getting started . . . . . Chapter 1

How costs and billing work . . . . . Chapter 2

Your medical benefits . . . . . Chapters 3, 4 and 5

Your preventive care benefits . . . . . Chapter 6

Your behavioral health benefits . . . . . Chapters 7, 8 and 9

What's not covered . . . . . Chapter 10

Types of healthcare providers . . . . . Chapter 11

Enrollment and membership . . . . . Chapter 12

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Plan definitions . . . . . Chapter 14

Your prescription drug benefits (from SilverScript) . . . . . Chapter 15

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