UniCare℠

Commonwealth of Massachusetts
Group Insurance Commission

Annual Enrollment News

For Basic, PLUS, and Community Choice members

The GIC's annual enrollment period runs from April 6 – May 4, 2022 for benefits effective July 1, 2022.

- ❑ If you want to continue in your UniCare plan, you don't need to take any action. Your coverage will continue automatically.
- ❑ If you do want to make a change, your enrollment deadline is May 4, 2022.

Why stay with UniCare?

- ❑ **The choice is always yours.** All UniCare plans continue to cover all providers. There's no network, and no requirements for PCPs or referrals to specialists. Outside Massachusetts, use the plan's contracted providers for the highest benefits at the lowest out-of-pocket costs. Our limited network plan, Community Choice, still offers you the lowest premium of all the non-Medicare plans offered through the GIC.
- ❑ **Our exceptional customer care team is second to none.** We believe that's what makes UniCare stand out most. Our member satisfaction scores consistently top 90%, and our members regularly renew year after year. Our representatives will give you the answers and the information you need.
- ❑ **Dedicated to you…and only you.** UniCare has just one client — the GIC. Because we don't offer health plans to the general public, we seldom advertise. But we've been a Massachusetts company offering health coverage exclusively to GIC members for more than 30 years. In fact, more GIC members are covered under UniCare than any other plan.
- ❑ **We're your trusted health partner for your whole health.** Our focus is on our members' whole health – physical, mental, emotional, and situational. Because the best health is whole health.

Visit unicaremass.com

- ❑ **Plan materials** – Access all your member materials in one place – provider listings, your 2022-2023 benefits summary, and plan resources that add value to your UniCare membership.
- ❑ **Explore Our Plans** – If you're thinking about switching to a different UniCare plan, this page lets you compare our three non-Medicare plans. You can also check the enclosed *Compare Our Plans* brochure.

Changes to your plan for the new plan year

- ❑ **PANDAS and PANS coverage** – Your plan will offer benefits for the treatment of PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections) and PANS (Pediatric Acute-Onset Neuropsychiatric Syndrome).
- ❑ **Additional behavioral health services** – Benefits for the following behavioral health services will now be available:
  - In-home behavioral services
  - Family support and training
  - Therapeutic mentoring services
  - Mobile crisis intervention
  - Intensive care coordination

Descriptions of these changes will be included in the 2022-2023 member handbook, available at unicaremass.com in June 2022.

Some important reminders

- ❑ **If you want to continue in your current UniCare plan, you don't have to do anything. Your coverage will continue automatically on July 1, 2022.** If you would like to switch to another UniCare plan, you can enroll from the GIC's website.
- ❑ **Create an account in our secure member portal at unicaremass.com/register.** You can check your claims and benefits, view your ID card, and access a wide variety of discounts on health and wellness products and services through our SpecialOffers program.
- ❑ **Check your specialists' tiers.** Go to unicaremass.com and choose **Find Care**. The tiers for specialty group practices in Massachusetts will not be changing. So if your doctor stays at the same group practice, his or her tier will stay the same for the new plan year.

Thank you for being a UniCare member and letting us serve you.

We appreciate the trust you've placed in us. As always, we will continue to put you first, providing dedicated member service and access to the health services you need.

Visit **unicaremass.com/annual-enrollment** for more information about this year's annual enrollment. If you have any questions, we are here for you. Call UniCare Member Services at 877-633-6396 or email us at contact.us@anthem.com.

UniCare SM

UNICARE STATE INDEMNITY PLAN

COMPARE OUR PLANS

Benefits effective July 1, 2022

Commonwealth of Massachusetts
Group Insurance Commission

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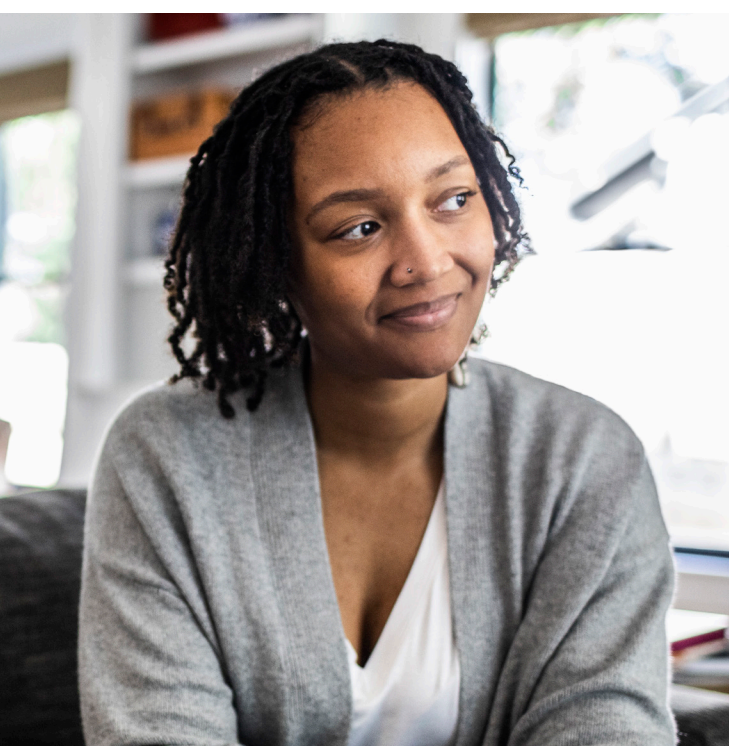
PERSONAL HEALTH BENEFITS FROM BIRTH TO RETIREMENT



At home in Massachusetts

The people insured through the Massachusetts Group Insurance Commission (GIC) share a dedication to public service. For more than 30 years, UniCare has been right here in Massachusetts, committed to serve the dedicated individuals – and their families – who serve our Commonwealth and its municipalities.

What makes UniCare different?

UniCare is the only health plan that offers medical benefits exclusively to GIC members. We are uniquely positioned to tailor what we do to those who receive their health coverage through the GIC.

Healthcare made easier

UniCare's health plans are designed with you in mind.

The choice is yours

No network — UniCare plans cover all doctors, facilities, and other healthcare providers. Use the plan's contracted providers for the highest benefits at the lowest out-of-pocket costs. The choice is always yours.

No referrals to specialists, no PCP requirement — Our plans do not require you to choose a primary care physician (PCP) or to obtain referrals for specialty office visits. Having a PCP is a good idea, and you're always free to ask your doctor for a specialist recommendation. It's entirely up to you.

Use any hospital

Receive services at any hospital, including the premier Boston-area teaching and research hospitals. With Community Choice, you pay a higher copay when you use certain hospitals.

Unparalleled customer service

UniCare's customer service is second to none. Our member satisfaction rates consistently top 90%, and our members regularly renew year after year.

Coverage beyond the Commonwealth

When you travel or live out of state, UniCare's travel network protects you from unexpected bills. And UniCare offers the only GIC plan that lets you live outside the U.S.

Behavioral health services

UniCare members have access to mental health and substance use services through Beacon Health's network, the largest behavioral health network in the country.

Support for staying healthy

An effective health plan won't just help when you're sick – it offers support and services to help you stay healthy.

UniCare plans offer a range of well-being tools and services. We'll help support your workout routine, provide services if you are expecting a child, and offer ideas and personal support for members dealing with chronic or other medical conditions.

The power of technology

UniCare is a leader in digital health. We offer new, robust mobile apps, web-based tools, and expanded virtual care options, so you can access care anytime, anywhere.

There is a UniCare plan for you

UniCare offers three health plans for non-Medicare GIC members and their families. Our plans vary by:

- Residency requirements (where you live).
- Providers that will bring the highest level of benefits.
- The amount you pay out of your own pocket when you receive care.
- The premiums you pay.

With three UniCare plans to choose from, there's sure to be one that works for you and your family.

HOW OUR PLANS COMPARE

	Basic with CIC Costs listed are with the comprehensive plan option	PLUS Costs listed are with PLUS providers	Community Choice Costs listed are with Community Choice hospitals
Plan requirements, deductible, and out-of-pocket maximum			
Primary care physician (PCP) required?	No	No	No
Referrals to specialists required?	No	No	No
Preapproval needed for certain services?	Yes	Yes	Yes
Deductible (individual/family)	$500/$1,000 per year	$500/$1,000 per year	$400/$800 per year
Maximum out-of-pocket (individual/family)	$5,000/$10,000 per year	$5,000/$10,000 per year	$5,000/$10,000 per year
Office visits (in person or virtual) and other non-hospital-based services			
Primary care physician (PCP) office visit	$20 copay per visit	$15 copay per visit (Centered Care PCPs) $20 copay per visit (all other PCPs)	$15 copay per visit (Centered Care PCPs) $20 copay per visit (all other PCPs)
Specialist office visit (Tier 1/Tier 2/Tier 3)	$30/$60/$60 copay per visit	$30/$60/$75 copay per visit	$30/$60/$75 copay per visit
Preventive care	No member cost	No member cost	No member cost
Virtual care through LiveHealth Online	$15 copay per visit	$15 copay per visit	$15 copay per visit
Urgent care and retail health clinic visit	$20 copay per visit	$20 copay per visit	$20 copay per visit
Behavioral health/substance use disorder outpatient care	$15/$20/$30 copay per visit	$15 copay per visit	$15/$20 copay per visit
High-tech imaging (such as an MRI, CT, or PET scan)	$100 copay per day and deductible	$100 copay per day and deductible	$100 copay per day and deductible
Services at a hospital			
Emergency room visit (copay waived if admitted)	$100 copay per visit and deductible	$100 copay per visit and deductible	$100 copay per visit and deductible
Inpatient hospital care	$275 copay per quarter and deductible	$275/$500/$1,500 copay per quarter and deductible	$275 copay per quarter and deductible
Outpatient surgery			
At a freestanding location (not owned by a hospital)	Deductible	Deductible	Deductible
At a hospital or hospital-owned location	$250 copay per quarter and deductible	$110/$110/$250 copay per quarter and deductible	$110 copay per quarter and deductible
Prescription drugs			
Pharmacy deductible (individual/family)	$100/$200 per year	$100/$200 per year	$100/$200 per year
Retail pharmacy – 30-day supply (Tier 1/Tier 2/Tier 3)	$10/$30/$65 copay per prescription	$10/$30/$65 copay per prescription	$10/$30/$65 copay per prescription
Mail order – 90-day supply (Tier 1/Tier 2/Tier 3)	$25/$75/$165 copay per prescription	$25/$75/$165 copay per prescription	$25/$75/$165 copay per prescription
	Basic without CIC	With non-PLUS providers	At non-Community Choice hospitals
	Many services covered at 80% (you owe 20% coinsurance)	Many services covered at 80% (you owe 20% coinsurance)	Many hospital services covered at 80% (you owe 20% coinsurance and a higher copay)

Note: There is no telehealth copay during the COVID-19 health emergency.

PLAN BY PLAN

The Basic plan is anything but basic

Compare to health maintenance organization (HMO) plans

With Basic, you're covered anywhere in the world, no matter where you live. You can see any doctor and use any hospital – the cost to you stays the same.

There's no hospital tiering in Basic. Your costs are the same whether you receive services at your nearby community hospital, at a Boston-area teaching hospital, or at a hospital on the other side of the country.

You're always free to see any primary care or specialty care doctor. There are two specialist tiers and, as with all UniCare plans, primary care doctors aren't tiered at all.

Basic with CIC (comprehensive coverage) offers the highest level of benefits – 100% coverage for most covered services – for a higher premium (monthly payment). You'll have a lower premium if you choose the non-CIC option, which covers many services at 80%.

Choose Basic if:

- You live outside New England for all or part of the year.
- You have dependents who receive regular healthcare in other states.
- You want the freedom to see any doctor — or go to any hospital — without any differences in coverage.
- You have complex medical needs.
- You're comfortable with a higher premium for better plan flexibility and access.

PLUS offers flexibility and choice

Compare to point of service (POS) plans

If you live in New England, check out the PLUS plan. PLUS offers great benefits and flexibility at a lower premium.

PLUS keeps your out-of-pocket costs lowest when you use PLUS providers. **All** doctors and hospitals in Massachusetts are PLUS providers. So are all UniCare-contracted doctors and hospitals in the other New England states.

You have access to all the PLUS hospitals, including the Boston-area hospitals, with three copay tiers. You'll pay the lowest copay at Tier 1 hospitals.

Your out-of-pocket costs will always be lowest when you use PLUS providers, but you're still free to use non-PLUS providers at the non-PLUS 80% benefit level.

Choose PLUS if:

- You and your dependents live and receive medical care in New England.
- You generally receive medical care near home, but want the choice to use other providers too.
- You want the option to use Boston-area teaching and research hospitals, and are willing to pay more out of pocket if you do.
- You're comfortable with a higher premium to ensure broader access to providers.

Community Choice

Compare to limited network plans

If you live in Massachusetts and receive hospital services at one of the 58 Community Choice hospitals, you'll enjoy the lowest premiums of any GIC offering, with the same benefits as our higher-premium plans.

In Community Choice, non-hospital services – including doctor visits – are covered the same no matter where you go or who you see.

The Community Choice plan is designed for those who receive their hospital services at a Community Choice hospital. But if the need arises, you still have the freedom to receive services at other hospitals at the non-Community Choice 80% benefit level.

Community Choice hospitals are located across Massachusetts – even Dana-Farber Cancer Institute in Boston and Children's Hospital Boston are Community Choice. There's bound to be a plan hospital near you.

Community Choice is not available in Nantucket or Martha's Vineyard.

Choose Community Choice if:

- You and your dependents live and receive medical care in Massachusetts.
- You receive most elective hospital services at a nearby community hospital.
- You'd like to keep your premium as low as possible.
- You're okay with paying more out of pocket if you receive services at a non-Community Choice hospital.

MASSACHUSETTS HOSPITALS (MEDICAL)

	Basic	PLUS Tier	Community Choice
Addison Gilbert Hospital	✓	1	✓
Anna Jaques Hospital	✓	1	✓
Athol Hospital	✓	1	✓
Baystate Franklin Medical Center	✓	1	✓
Baystate Medical Center	✓	1	✓
Berkshire Medical Center	✓	1	✓
Beth Israel Deaconess Medical Center – Boston	✓	2	✓
Beverly Hospital	✓	1	✓
Boston Children's Hospital	✓	2	✓
Boston Medical Center	✓	3	
Brigham and Women's Hospital	✓	3	
Brockton Hospital (Signature Healthcare)	✓	1	✓
Burbank Hospital (UMass Memorial HealthAlliance)	✓	2	✓
Cambridge Hospital (Cambridge Health Alliance)	✓	1	✓
Cape Cod Hospital	✓	1	✓
Carney Hospital	✓	1	✓
Charlton Memorial Hospital (Southcoast)	✓	1	✓
Clinton Hospital (UMass Memorial HealthAlliance)	✓	2	
Cooley Dickinson Hospital	✓	2	✓
Dana-Farber Cancer Institute – Boston	✓	2	✓
Emerson Hospital	✓	1	✓
Everett Hospital – Whidden (Cambridge Health Alliance)	✓	1	✓
Fairview Hospital	✓	1	✓
Falmouth Hospital	✓	2	
Faulkner Hospital (Brigham and Women's)	✓	3	
Framingham Union Hospital (Metrowest)	✓	1	✓
Good Samaritan Medical Center	✓	1	✓
Harrington Memorial Hospital	✓	1	✓
Heywood Hospital	✓	1	✓
Holy Family Hospital – Merrimack Valley	✓	1	✓
Holy Family Hospital – Methuen	✓	1	✓
Holyoke Medical Center	✓	1	✓
Lahey Hospital & Medical Center – Burlington	✓	3	✓
Lahey Medical Center – Peabody	✓	3	✓
Lawrence General Hospital	✓	1	✓
Lawrence Memorial Hospital of Medford	✓	1	✓
Leominster Hospital (UMass Memorial HealthAlliance)	✓	2	✓

	Basic	PLUS Tier	Community Choice
Lowell General Hospital	✓	1	✓
Marlborough Hospital (UMass Memorial)	✓	2	
Martha's Vineyard Hospital	✓	2	
Massachusetts Eye and Ear	✓	2	✓
Massachusetts General Hospital	✓	3	
MassGeneral for Children at North Shore Medical Center	✓	3	
Melrose-Wakefield Hospital	✓	1	✓
Mercy Medical Center	✓	1	✓
Milford Regional Medical Center	✓	1	✓
Milton Hospital (Beth Israel Deaconess)	✓	2	✓
Morton Hospital	✓	1	✓
Mount Auburn Hospital	✓	1	✓
Nantucket Cottage Hospital	✓	2	
Nashoba Valley Medical Center	✓	1	✓
Needham Hospital (Beth Israel Deaconess)	✓	2	✓
New England Baptist Hospital	✓	2	✓
Newton-Wellesley Hospital	✓	3	
Noble Hospital (Baystate)	✓	1	✓
North Shore Medical Center	✓	3	
Norwood Hospital	✓	1	✓
Plymouth Hospital (Beth Israel Deaconess)	✓	2	✓
Saint Vincent Hospital	✓	1	✓
Saints Medical Center (Lowell General)	✓	1	✓
Salem Hospital (North Shore Medical Center)	✓	3	
Shriner's Hospital for Children – Boston	✓	2	✓
Shriner's Hospital for Children – Springfield	✓	2	✓
South Shore Hospital	✓	1	✓
St. Anne's Hospital	✓	1	✓
St. Elizabeth's Medical Center	✓	1	✓
St. Luke's Hospital (Southcoast)	✓	1	✓
Sturdy Memorial Hospital	✓	1	✓
Tobey Hospital (Southcoast)	✓	1	✓
Tufts Medical Center	✓	3	
UMass Memorial Medical Center	✓	2	
Union Hospital (North Shore Medical Center)	✓	3	
Winchester Hospital	✓	1	✓
Wing Hospital (Baystate)	✓	1	✓

HEART. INNOVATION. COMMUNITY. UNICARE.

With three comprehensive plans for non-Medicare GIC members – there's a UniCare plan to support the healthcare needs of you and your family.

To learn more:

- Call UniCare Member Services toll free at **877-633-6396** (TTY: 711).
- Go to **unicaremass.com/annual-enrollment.**

If you're a Medicare-eligible GIC member:

- Call **877-633-6396** to find out about UniCare's Medicare Extension plan.

Already a UniCare member?

- You don't need to take any action. Your coverage will continue automatically.

For questions about enrolling:

- See your *GIC Benefit Decision Guide* for information about deadlines and how to enroll.
- Go to the GIC's website at **mass.gov/gic**.

UniCare℠

UniCare State Indemnity Plan
P.O. Box 9016
Andover, MA 01810
877-633-6396

Visit UniCare's website at unicaremass.com

Commonwealth of Massachusetts
Group Insurance Commission

UniCare

UNICARE STATE INDEMNITY PLAN

PLAN BENEFITS – BASIC

Effective July 1, 2022

Summary of Basic plan benefits

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

- **Deductible** – The Basic plan deductible is $500 for one person or $1,000 for a family each plan year.
- **Out-of-pocket cost limits** – The **out-of-pocket maximum** ($5,000 for one person and $10,000 for a family) limits your costs for medical, behavioral health, and pharmacy services.
- **Allowed amounts** – All benefits shown in this summary are limited to UniCare's allowed amounts. The allowed amount is the most that UniCare pays for a covered service.
- **Preapprovals** – Services marked with a ☎ phone symbol need to be preapproved.

Benefits for medical care under Basic

Service	Your member costs with CIC	Your member costs without CIC
Ambulances	Deductible	Deductible
Anesthesia	Deductible	Deductible and 20% coinsurance
Bereavement counseling	Deductible and 20% coinsurance *(limited to $1,500 for a family in a plan year)*	Deductible and 20% coinsurance *(limited to $1,500 for a family in a plan year)*
Cardiac rehab programs	Deductible	Deductible
Chemotherapy	Deductible	Deductible and 20% coinsurance
Chiropractic care	$20 copay and 20% coinsurance *(limited to 20 visits in a plan year)*	$20 copay and 20% coinsurance *(limited to 20 visits in a plan year)*
Diabetic supplies	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance
Dialysis	Deductible	Deductible and 20% coinsurance
Doctor visits (in person or virtual care)		
▪ Primary care (PCP) visits	$20 copay	$20 copay and 20% coinsurance
▪ Specialist visits	$30/60/60 copay	$30/60/60 copay and 20% coinsurance
▪ LiveHealth Online virtual care	$15 copay	$15 copay and 20% coinsurance
Doctors – other services		
▪ At an emergency room	Deductible	Deductible and 20% coinsurance
▪ Inpatient hospital care	Deductible	Deductible and 20% coinsurance
▪ Outpatient hospital care	$30/60/60 copay	$30/60/60 copay and 20% coinsurance
Drug screening (lab tests)	Deductible	Deductible
☎ **Durable medical equipment (DME)**	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance
Early intervention programs	No member costs	No member costs

Service	Your member costs with CIC	Your member costs without CIC
Emergency room visits	$100 copay and deductible	$100 copay and deductible
☎ **Enteral therapy**	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance
Eye exams (routine)	$30/60/60 copay *(limited to one exam every 24 months)*	$30/60/60 copay *(limited to one exam every 24 months)*
Eyeglasses and contact lenses	Deductible and 20% coinsurance *(limited to the first lenses within six months after eye injury or cataract surgery)*	Deductible and 20% coinsurance *(limited to the first lenses within six months after eye injury or cataract surgery)*
Family planning services	No member costs	No member costs
Fitness reimbursement	Reimbursed up to $100 for the family in a plan year	Reimbursed up to $100 for the family in a plan year
Hearing aids		
▪ Age 21 and under	No member costs *(limited to $2,000 for each impaired ear every 24 months)*	No member costs *(limited to $2,000 for each impaired ear every 24 months)*
▪ Age 22 and over	No member costs for first $500, then 20% coinsurance of the next $1,500 *(up to a total benefit limit of $1,700 every 24 months)*	No member costs for first $500, then 20% coinsurance of the next $1,500 *(up to a total benefit limit of $1,700 every 24 months)*
Hearing exams	$20/30/60 copay	$20/30/60 copay and 20% coinsurance
☎ **High-tech imaging (e.g., MRIs, CT and PET scans)**		
▪ Inpatient hospital	Deductible	Deductible
▪ Outpatient hospital and non-hospital-owned locations	$100 daily copay and deductible	$100 daily copay, deductible, and 20% coinsurance
☎ **Home health care**	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance
Home infusion therapy	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance
Hospice care	Deductible	Deductible
Immunizations (vaccines)	No member costs *(you may have costs for an office visit)*	No member costs *(you may have costs for an office visit)*
☎ **Inpatient services**		
▪ At a hospital or rehab facility (semi-private room)	$275 quarterly copay and deductible	▪ **First 120 days:** $300 quarterly copay and deductible ▪ **After 120 days:** 20% coinsurance
▪ At a hospital or rehab facility (medically necessary private room)	▪ **First 90 days:** $275 quarterly copay and deductible ▪ **After 90 days:** Dollar difference between the semi-private room rate and the private room rate	▪ **First 90 days:** $300 quarterly copay and deductible ▪ **Days 91 to 120:** Dollar difference between the semi-private room rate and the private room rate ▪ **After 120 days:** 20% coinsurance, and the dollar difference between the semi-private room rate and the private room rate

Service	Your member costs with CIC	Your member costs without CIC
Lab services	Deductible	Deductible
☎ **Occupational therapy**	$20 copay	$20 copay
Office visits	*See "Doctor visits" on page 1.*	
Oxygen	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance	▪ **Preferred vendors:** Deductible ▪ **Non-preferred vendors:** Deductible and 20% coinsurance
Personal Emergency Response Systems (PERS)		
▪ Installation	Deductible and 20% coinsurance *(limited to $50 in a plan year)*	Deductible and 20% coinsurance *(limited to $50 in a plan year)*
▪ Rental	Deductible and 20% coinsurance *(limited to $40 a month)*	Deductible and 20% coinsurance *(limited to $40 a month)*
☎ **Physical therapy**	$20 copay	$20 copay
Prescription drugs	▪ From a network pharmacy (30-day supply): $10/30/65 copay ▪ By mail order (90-day supply): $25/75/165 *These benefits are administered by Express Scripts. Call 855-283-7679 for information.*	
Preventive care	No member costs	No member costs
☎ **Private duty nursing in a home setting**	Deductible and 20% coinsurance *(limited to $8,000 in a plan year)*	Deductible and 20% coinsurance *(limited to $4,000 in a plan year)*
Prosthetics and orthotics		
▪ Breast prosthetics	Deductible	Deductible
▪ Other prosthetics and orthotics	Deductible and 20% coinsurance	Deductible and 20% coinsurance
☎ **Radiation therapy**	Deductible	Deductible and 20% coinsurance
Radiology (e.g., X-rays)		
▪ Inpatient hospital	Deductible	Deductible
▪ Outpatient hospital and non-hospital-owned locations	Deductible	Deductible and 20% coinsurance
Retail health clinic visits	$20 copay	$20 copay and 20% coinsurance
☎ **Skilled nursing and long-term care facilities**	Deductible and 20% coinsurance *(limited to 45 days in a plan year)*	Deductible and 20% coinsurance *(limited to 45 days in a plan year)*
☎ **Sleep studies**	Deductible	Deductible and 20% coinsurance
☎ **Speech therapy**		
▪ With an autism diagnosis	No member costs	20% coinsurance
▪ All other speech therapy	No member costs *(limited to 20 visits in a plan year)*	20% coinsurance *(limited to 20 visits in a plan year)*
☎ **Surgery**		
▪ Inpatient hospital	Deductible *(you also have an inpatient copay; see "Inpatient services")*	Deductible and 20% coinsurance *(you also have an inpatient copay; see "Inpatient")*
▪ Outpatient hospital	$250 quarterly copay and deductible	$250 quarterly copay, deductible, and 20% coinsurance
▪ Non-hospital-owned locations	Deductible	Deductible and 20% coinsurance

Service	Your member costs with CIC	Your member costs without CIC
Tobacco cessation counseling	No member costs *(limited to 300 minutes in a plan year)*	No member costs *(limited to 300 minutes in a plan year)*
☎ **Transplants**		
▪ At a Quality Center or Designated Hospital for transplants	$275 quarterly copay and deductible	$300 quarterly copay and deductible
▪ At other hospitals	$275 quarterly copay, deductible, and 20% coinsurance	$300 quarterly copay, deductible, and 20% coinsurance
Urgent care center visits	$20 copay	$20 copay and 20% coinsurance
Virtual care (telehealth)	*See "Doctor visits" on page 1.*	
Wigs (after cancer treatment)	20% coinsurance	20% coinsurance

Benefits for behavioral health care under Basic

Service	Your member costs with CIC	Your member costs without CIC
Emergency service programs	No member costs	No member costs
☎ **Inpatient care**		
▪ Facility charges	$150 quarterly copay	$150 quarterly copay
▪ Professional services	No member costs	No member costs
Medication-assisted treatment	No member costs	No member costs
Medication management	$15 copay	$15 copay
☎ **Office services**	$20/30 copay	$20/30 copay
☎ **Outpatient services**	Deductible	Deductible
Substance use disorder assessment / referral	No member costs	No member costs
Therapy		
▪ Individual therapy	$20/30 copay	$20/30 copay
▪ Family therapy	$20/30 copay	$20/30 copay
▪ Group therapy	$15 copay	$15 copay
Virtual care (telehealth) *When using LiveHealth Online or a contracted provider, you don't owe a copay for the first three visits.*	▪ **LiveHealth Online:** $15 copay ▪ **Other providers:** Copay of the service being provided	▪ **LiveHealth Online:** $15 copay ▪ **Other providers:** Copay of the service being provided

Acute Care Medical Hospitals in Massachusetts

Basic: $275 quarterly copay PLUS: $275/500/1,500 quarterly copay Community Choice: $275 quarterly copay	Basic	PLUS Tier	Cmty Choice
Addison Gilbert Hospital	✓	1	✓
Anna Jaques Hospital	✓	1	✓
Athol Hospital	✓	1	✓
Baystate Franklin Medical Center	✓	1	✓
Baystate Medical Center	✓	1	✓
Berkshire Medical Center	✓	1	✓
Beth Israel Deaconess Medical Center – Boston	✓	2	✓
Beverly Hospital	✓	1	✓
Boston Children's Hospital	✓	2	✓
Boston Medical Center	✓	3	
Brigham and Women's Hospital	✓	3	
Brockton Hospital (Signature Healthcare)	✓	1	✓
Burbank Hospital (UMass Memorial HealthAlliance)	✓	2	✓
Cambridge Hospital (Cambridge Health Alliance)	✓	1	✓
Cape Cod Hospital	✓	1	✓
Carney Hospital	✓	1	✓
Charlton Memorial Hospital (Southcoast)	✓	1	✓
Clinton Hospital (UMass Memorial HealthAlliance)	✓	2	
Cooley Dickinson Hospital	✓	1	✓
Dana-Farber Cancer Institute – Boston	✓	2	✓*
Emerson Hospital	✓	1	✓
Everett Hospital – Whidden (Cambridge Health Alliance)	✓	1	✓
Fairview Hospital	✓	1	✓
Falmouth Hospital	✓	2	
Faulkner Hospital (Brigham and Women's)	✓	3	
Framingham Union Hospital (MetroWest)	✓	1	✓
Good Samaritan Medical Center	✓	1	✓
Harrington Memorial Hospital	✓	1	✓
Heywood Hospital	✓	1	✓
Holy Family Hospital – Merrimack Valley	✓	1	✓
Holy Family Hospital – Methuen	✓	1	✓
Holyoke Medical Center	✓	1	✓
Lahey Hospital & Medical Center – Burlington	✓	3	✓
Lahey Medical Center – Peabody	✓	3	✓
Lawrence General Hospital	✓	1	✓
Lawrence Memorial Hospital of Medford	✓	1	✓
Leominster Hospital (UMass Memorial HealthAlliance)	✓	2	✓

Basic: $275 quarterly copay PLUS: $275/500/1,500 quarterly copay Community Choice: $275 quarterly copay	Basic	PLUS Tier	Cmty Choice
Lowell General Hospital	✓	1	✓
Marlborough Hospital (UMass Memorial)	✓	2	
Martha's Vineyard Hospital	✓	2	
Massachusetts Eye and Ear	✓	2	✓
Massachusetts General Hospital	✓	3	
MassGeneral for Children at North Shore Medical Center	✓	3	
Melrose-Wakefield Hospital	✓	1	✓
Mercy Medical Center	✓	1	✓
Milford Regional Medical Center	✓	1	✓
Milton Hospital (Beth Israel Deaconess)	✓	2	✓
Morton Hospital	✓	1	✓
Mount Auburn Hospital	✓	1	✓
Nantucket Cottage Hospital	✓	2	
Nashoba Valley Medical Center	✓	1	✓
Needham Hospital (Beth Israel Deaconess)	✓	2	✓
New England Baptist Hospital	✓	2	✓
Newton-Wellesley Hospital	✓	3	
Noble Hospital (Baystate)	✓	1	✓
North Shore Medical Center	✓	3	
Norwood Hospital	✓	1	✓
Plymouth Hospital (Beth Israel Deaconess)	✓	2	✓
Saint Vincent Hospital	✓	1	✓
Saints Medical Center (Lowell General)	✓	1	✓
Salem Hospital (North Shore Medical Center)	✓	3	
Shriner's Hospital for Children – Boston	✓	2	✓
Shriner's Hospital for Children – Springfield	✓	2	✓
South Shore Hospital	✓	1	✓
St. Anne's Hospital	✓	1	✓
St. Elizabeth's Medical Center	✓	1	✓
St. Luke's Hospital (Southcoast)	✓	1	✓
Sturdy Memorial Hospital	✓	1	✓
Tobey Hospital (Southcoast)	✓	1	✓
Tufts Medical Center	✓	3	
UMass Memorial Medical Center	✓	2	
Union Hospital (North Shore Medical Center)	✓	3	
Winchester Hospital	✓	1	✓
Wing Hospital (Baystate)	✓	1	✓

* Dana-Farber often admits patients to Brigham & Women's Hospital for inpatient care. If you are admitted to the Brigham directly from Dana-Farber, please contact UniCare to avoid paying the non-Community Choice copay and coinsurance.

UniCare℠

(833) 663-4176

Commonwealth of Massachusetts
Group Insurance Commission

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.unicaremass.com/handbook-basic-fy23 or call 833-663-4176. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 833-663-4176 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For all providers: **$500**/person or **$1,000**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and contracted (network) behavioral health services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copay or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$100**/person or **$200**/family for prescription drugs per benefit period. Prescription drug coverage is administered through Express Scripts.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical, prescription drug and contracted (network) behavioral health (shared): **$5,000**/person or **$10,000**/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other familiy members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, for behavioral health services. Go to unicaremass.com or call 833-663-4176 (TTY: 711) for a list of contracted (network) providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contracted Provider (You will pay the least)	Non-contracted Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit Deductible does not apply		None
	Specialist visit	In MA: Tier 1: $30 copay/visit Tier 2: $60 copay/visit Tier 3: $60 copay/visit Outside MA and other specialists: $60 copay/visit Deductible does not apply		None
	Preventive care/screening/ immunization	No charge Deductible does not apply		You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (X-ray, blood work)	No charge		None
	Imaging (CT/PET scans, MRIs)	$100 copay/day		Preauthorization is required for some procedures.
If you need drugs to treat your illness or condition ***Benefits provided by Express Scripts*** More information about prescription drug coverage is available at express-scripts.com Phone: 855-283-7679	Tier 1 – Generic drugs	$10 copay/prescription (retail) $25 copay/prescription (mail order)		Retail cost share is for up to a 30-day supply; mail order cost share is for up to a 90-day supply. Some drugs require prior authorization to be covered. Some drugs have quantity limitations. A 90-day supply of maintenance medications may be obtained at a CVS Pharmacy for the applicable mail order copay. If a drug has a generic equivalent, and you buy the brand name (even if your physician indicates no substitutions), you will pay the generic-level copay plus the cost difference between the generic and the brand name drug.
	Tier 2 – Preferred brand and some generic drugs	$30 copay/prescription (retail) $75 copay/prescription (mail order)		
	Tier 3 – Non-preferred brand drugs	$65 copay/prescription (retail) $165 copay/prescription (mail order)		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contracted Provider (You will pay the least)	Non-contracted Provider (You will pay the most)	
	Specialty drugs	Limited to a 30-day supply with appropriate tier copay (see above) when purchased at a designated specialty pharmacy.		Limited to a 30-day supply. Must be filled through Accredo, an Express Scripts specialty pharmacy. Some drugs require prior authorization to be covered. Some drugs have quantity limitations. Some specialty drugs may also be covered under your medical benefit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	At a hospital facility: $250 copay/calendar quarter At a non-hospital facility: No charge		Preauthorization is required for some surgeries.
	Physician/surgeon fees	No charge		
If you need immediate medical attention	Emergency room care	$100 copay/visit (waived if admitted)		None
	Emergency medical transportation	No charge		Covered only for transportation to the nearest facility equipped to treat the condition.
	Urgent care	$20 copay/visit Deductible does not apply		Applies to stand-alone, non-hospital-owned facilities only.
If you have a hospital stay	Facility fee (e.g., hospital room)	$275 copay/calendar quarter		Preauthorization is required.
	Physician/surgeon fees	No charge		
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	Office services, individual therapy, family therapy: $20 copay/visit; deductible does not apply Group therapy, medication management services: $15 copay/visit; deductible does not apply Telehealth visits: no cost for first three visits then $15/copay/visit	Office services, individual therapy, family therapy: $30 copay/visit; deductible does not apply Group therapy, medication management: $15 copay/visit; deductible does not apply Telehealth visits: $15/copay/visit	**Substance Use Disorder Services**: Preauthorization is not required for treatment from Massachusetts Department of Public Health (DPH) licensed providers.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contracted Provider (You will pay the least)	Non-contracted Provider (You will pay the most)	
	Inpatient services	$150 copay/calendar quarter Deductible does not apply	$150 copay/calendar quarter Deductible does not apply	**Mental Health Services:** Services in a general hospital or psychiatric hospital may require preauthorization. **Substance Use Disorder Services:** Services in a general hospital or substance use disorder facility. Preauthorization is required for non-contracted facilities that are outside of Massachusetts only.
If you are pregnant	Office visits	$30/60/60 copay for first visit Deductible does not apply		Most maternity care is billed as a global (all-inclusive) service so you owe an office visit copay for the first visit only. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound). Preauthorization is required for delivery.
	Childbirth/delivery professional services	No charge		
	Childbirth/delivery facility services	$275 copay/calendar quarter		
If you need help recovering or have other special health needs	Home health care	Preferred vendors: No charge Non-preferred vendors: 20% coinsurance		Preauthorization is required.
	Rehabilitation services	Physical and occupational therapy: $20 copay/visit Deductible does not apply		Preauthorization is required.
		Speech therapy: No charge Deductible does not apply		Limit of 20 visits/plan year Preauthorization is required.
	Habilitation services	Early intervention services for children under age 3: No charge Deductible does not apply		None
	Skilled nursing care	20% coinsurance		Limit of 45 days/plan year in an inpatient facility
	Durable medical equipment	Preferred vendors: No charge Non-preferred vendors: 20% coinsurance Deductible does not apply to breast pumps		Preauthorization is required if costs will be more than $1,000.
	Hospice services	No charge		None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contracted Provider (You will pay the least)	Non-contracted Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Optometrist: $60 copay/visit Ophthalmologist In MA: Tier 1: $30 copay/visit Tier 2: $60 copay/visit Tier 3: $60 copay/visit Ophthalmologist outside MA: $60 copay/visit Deductible does not apply		Routine eye exams including refraction and glaucoma testing Limit of one exam every 24 months
	Children's glasses	Not covered		None
	Children's dental check-up	Not covered		None

Excluded Services & Other Covered Services:

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

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care (limit of 20 visits/plan year)
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private duty nursing (at home only)
- Routine eye care (adult)
- Routine foot care (when diagnosis is diabetes or peripheral vascular disease)
- Weight loss programs (when BMI is 40 or higher)

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

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

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

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

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

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	$600
Specialist copay	$30/60/60
Hospital (facility) copay	$275
Other coinsurance	20%

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

Total Example Cost	**$12,840**

In this example, Peg would pay:

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

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

The plan's overall deductible	$600
Specialist copay	$30/60/60
Hospital (facility) copay	$275
Other coinsurance	20%

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

Total Example Cost	**$7,460**

In this example, Joe would pay:

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

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

The plan's overall deductible	$600
Specialist copay	$30/60/60
Hospital (facility) copay	$275
Other coinsurance	20%

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

Total Example Cost	**$2,010**

In this example, Mia would pay:

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

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

Language Access Services:

(TTY/TDD: 711)

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

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

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

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

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

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

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

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

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

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

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

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

Language Access Services:

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

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

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

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

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the member services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	For all providers: **$500**/person or **$1,000**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and contracted (network) behavioral health services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copay or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$100**/person or **$200**/family for prescription drugs per benefit period. Prescription drug coverage is administered through Express Scripts.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical, prescription drug and contracted (network) behavioral health (shared): **$5,000**/person or **$10,000**/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other familiy members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, for behavioral health services Go to unicaremass.com or call 833-663-4176 (TTY: 711) for a list of contracted (network) providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contracted Provider (You will pay the least)	Non-contracted Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit and 20% coinsurance Deductible does not apply		None
	Specialist visit	In MA: Tier 1: $30 copay/visit and 20% coinsurance Tier 2: $60 copay/visit and 20% coinsurance Tier 3: $60 copay/visit and 20% coinsurance Outside MA and other specialists: $60 copay/visit and 20% coinsurance Deductible does not apply		None
	Preventive care/screening/ immunization	No charge Deductible does not apply		You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (X-ray, blood work)	Diagnostic lab work: No charge Radiology: 20% coinsurance		None
	Imaging (CT/PET scans, MRIs)	$100 copay/day and 20% coinsurance		Preauthorization is required for some procedures.
If you need drugs to treat your illness or condition ***Benefits provided by Express Scripts*** More information about prescription drug coverage is available at express-scripts.com Phone: 855-283-7679	Tier 1 – Generic drugs	$10 copay/prescription (retail) $25 copay/prescription (mail order)		Retail cost share is for up to a 30-day supply; mail order cost share is for up to a 90-day supply. Some drugs require prior authorization to be covered. Some drugs have quantity limitations. A 90-day supply of maintenance medications may be obtained at a CVS Pharmacy for the applicable mail order copay. If a drug has a generic equivalent, and you buy the brand name (even if your physician indicates no substitutions), you will pay the generic-level copay plus the cost difference between the generic and the brand name drug.
	Tier 2 – Preferred brand and some generic drugs	$30 copay/prescription (retail) $75 copay/prescription (mail order)		
	Tier 3 – Non-preferred brand drugs	$65 copay/prescription (retail) $165 copay/prescription (mail order)		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contracted Provider (You will pay the least)	Non-contracted Provider (You will pay the most)	
	Specialty drugs	Limited to a 30-day supply with appropriate tier copay (see above) when purchased at a designated specialty pharmacy.		Limited to a 30-day supply. Must be filled through Accredo, an Express Scripts specialty pharmacy. Some drugs require prior authorization to be covered. Some drugs have quantity limitations. Some specialty drugs may also be covered under your medical benefit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	At a hospital facility: $250 copay/calendar quarter and 20% coinsurance At a non-hospital facility: 20% coinsurance		Preauthorization is required for some surgeries.
	Physician/surgeon fees	20% coinsurance		
If you need immediate medical attention	Emergency room care	$100 copay/visit (waived if admitted)		None
	Emergency medical transportation	20% coinsurance after the first $25		Covered only for transportation to the nearest facility equipped to treat the condition.
	Urgent care	$20 copay/visit and 20% coinsurance Deductible does not apply		Applies to stand-alone, non-hospital-owned facilities only.
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay/calendar quarter		Preauthorization is required.
	Physician/surgeon fees	20% coinsurance		
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	Office services, individual therapy, family therapy: $20 copay/visit; deductible does not apply Group therapy, medication management services: $15 copay/visit; deductible does not apply Telehealth visits: no cost for first three visits then $15/copay/visit	Office services, individual therapy, family therapy: $30 copay/visit; deductible does not apply Group therapy, medication management: $15 copay/visit; deductible does not apply Telehealth visits: $15/copay/visit	**Substance Use Disorder Services**: Preauthorization is not required for treatment from Massachusetts Department of Public Health (DPH) licensed providers.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contracted Provider (You will pay the least)	Non-contracted Provider (You will pay the most)	
	Inpatient services	$150 copay/calendar quarter Deductible does not apply	$150 copay/calendar quarter Deductible does not apply	**Mental Health Services:** Services in a general hospital or psychiatric hospital may require preauthorization. **Substance Use Disorder Services**: Services in a general hospital or substance use disorder facility. Preauthorization is required for non-contracted facilities that are outside of Massachusetts only.
If you are pregnant	Office visits	$30/60/60 copay for first visit and 20% coinsurance Deductible does not apply		Most maternity care is billed as a global (all-inclusive) service so you owe a copay and coinsurance for the first visit only. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound). Preauthorization is required for delivery.
	Childbirth/delivery professional services	20% coinsurance		
	Childbirth/delivery facility services	$300 copay/calendar quarter		
If you need help recovering or have other special health needs	Home health care	Preferred vendors: No charge Non-preferred vendors: 20% coinsurance		Preauthorization is required.
	Rehabilitation services	Physical and occupational therapy: $20 copay/visit Deductible does not apply		Preauthorization is required.
		Speech therapy: 20% coinsurance Deductible does not apply		Limit of 20 visits/plan year Preauthorization is required.
	Habilitation services	Early intervention services for children under age 3: No charge Deductible does not apply		None
	Skilled nursing care	20% coinsurance		Limit of 45 days/plan year in an inpatient facility
	Durable medical equipment	Preferred vendors: No charge Non-preferred vendors: 20% coinsurance Deductible does not apply to breast pumps		Preauthorization is required if costs will be more than $1,000.
	Hospice services	No charge		None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contracted Provider (You will pay the least)	Non-contracted Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Optometrist: $60 copay/visit Ophthalmologist In MA: Tier 1: $30 copay/visit Tier 2: $60 copay/visit Tier 3: $60 copay/visit Ophthalmologist outside MA: $60 copay/visit Deductible does not apply		Routine eye exams including refraction and glaucoma testing Limit of one exam every 24 months
	Children's glasses	Not covered		None
	Children's dental check-up	Not covered		None

Excluded Services & Other Covered Services:

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

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care (limit of 20 visits/plan year)
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private duty nursing (at home only)
- Routine eye care (adult)
- Routine foot care (when diagnosis is diabetes or peripheral vascular disease)
- Weight loss programs (when BMI is 40 or higher)

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

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

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

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

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

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	**$600**
Specialist copay	**$30/60/60**
Hospital (facility) copay	**$300**
Other coinsurance	**20%**

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

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$540
Copays	$300
Coinsurance	$550
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,450**

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

The plan's overall deductible	**$600**
Specialist copay	**$30/60/60**
Hospital (facility) copay	**$300**
Other coinsurance	**20%**

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

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copays	$840
Coinsurance	$180
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,640**

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

The plan's overall deductible	**$600**
Specialist copay	**$30/60/60**
Hospital (facility) copay	**$300**
Other coinsurance	**20%**

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

Total Example Cost	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copays	$240
Coinsurance	$120
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$860**

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

Language Access Services:

(TTY/TDD: 711)

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

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

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

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

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

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

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

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

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

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

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

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

Language Access Services:

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

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

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

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

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the member services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.