UniCare

UNICARE STATE INDEMNITY PLAN

PLAN BENEFITS – BASIC

Effective July 1, 2021

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.

Telehealth notice

Regulations concerning future telehealth benefits are currently under review in Massachusetts. For updates on telehealth services, requirements, and benefits, check unicaremass.com.

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 telehealth		
▪ 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	$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

Service	Your member costs with CIC	Your member costs without CIC
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
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

Service	Your member costs with CIC	Your member costs without CIC
☎ **Inpatient services** *(continued)* ▪ 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
Lab services	Deductible	Deductible
☎ **Occupational therapy**	$20 copay	$20 copay
Office visits	*See "Doctor visits – in-person or telehealth" 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)*

Service	Your member costs with CIC	Your member costs without CIC
☎ **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
Telehealth	*See "Doctor visits – in-person or telehealth" on page 1.*	
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
Wigs (after cancer treatment)	20% coinsurance	20% coinsurance

Benefits for behavioral health care under Basic

Service – Visits may be in-person or telehealth	Your member costs with CIC	Your member costs without CIC
Emergency service programs	No member costs	No member costs
☎ **Inpatient services**	$150 quarterly copay	$150 quarterly copay
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
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
Therapy		
▪ Individual therapy	$20/30 copay	$20/30 copay
▪ Family therapy	$20/30 copay	$20/30 copay
▪ Group therapy	$15 copay	$15 copay