Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
UniCare State Indemnity Plan/Total Choice

Coverage Period: 07/01/2023-06/30/2024
Coverage for: Individual/Family | **Plan Type:** Indemnity

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/docs/inline/handbook-totalchoice-fy24.pdf 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 CVS Caremark.	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	$45 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 CVS Caremark*** More information about prescription drug coverage is available at caremark.com Phone: 877-876-7214	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)		
	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.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	At a hospital facility: $250 copay/calendar quarter Eye and GI surgery at a non-hospital facility: $150 copay/calendar quarter All other surgery at a non-hospital facility: $250 copay/calendar quarter At a doctor's office: $20 copay/visit (PCP); $45 copay/visit (specialist)		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	$20 copay/visit (no cost for first three telehealth visits) Deductible does not apply	20% coinsurance	**Substance Use Disorder Services**: Preauthorization is not required for treatment from Massachusetts Department of Public Health (DPH) licensed providers. No cost for first three telehealth visits
	Inpatient services	$275 copay/calendar quarter	20% coinsurance	**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	$45 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.
	Childbirth/delivery professional services	No charge		

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)	
	Childbirth/delivery facility services	$275 copay/calendar quarter		Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound). Preauthorization is required for delivery.
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		Limit of 30 visits/plan year. Preauthorization is required.
		Speech therapy: $20 copay/visit Deductible does not apply		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 100 days/plan year in an inpatient facility
	Durable medical equipment	Preferred vendors: No charge (deductible does not apply to breast pumps) Non-preferred vendors: 20% coinsurance		Preauthorization is required if costs will be more than $1,000.
	Hospice services	No charge		Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	$45 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.)

- Cosmetic surgery
- Dental care (adult)
- Long-term care
- Private duty nursing

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

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

* For more information about limitations and exceptions, see the plan or policy document at www.unicaremass.com/docs/inline/handbook-totalchoice-fy24.pdf

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	$500
Specialist copay	$45
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	$500
Specialist copay	$45
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	$870
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,490**

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

The plan's overall deductible	$500
Specialist copay	$45
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	$270
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$770**

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.