

PLAN BENEFITS – PLUS

Effective July 1, 2022






Summary of PLUS plan benefits

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

- ❑ **Deductibles** – The **PLUS deductible**, which applies to services from PLUS providers, is \$500 for one person or \$1,000 for a family each plan year. The separate **non-PLUS deductible** of \$500 for one person – or \$1,000 for a family – applies to services from non-PLUS providers.
- ❑ **Out-of-pocket cost limits** – The **PLUS out-of-pocket maximum** (\$5,000 for one person and \$10,000 for a family) limits your costs for services with PLUS providers. The separate **non-PLUS out-of-pocket maximum** (\$5,000 and \$10,000) limits your costs with non-PLUS providers.
- ❑ **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 PLUS

Service	Your member costs with PLUS providers	Your member costs with non-PLUS providers
Ambulances	PLUS deductible	PLUS deductible
Anesthesia	PLUS deductible	Non-PLUS deductible then 20% coinsurance
Bereavement counseling	PLUS deductible and 20% coinsurance <i>(limited to \$1,500 for a family in a plan year)</i>	Non-PLUS deductible and 20% coinsurance <i>(limited to \$1,500 for a family a plan year)</i>
Cardiac rehab programs	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Chemotherapy	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Chiropractic care	\$20 copay and 20% coinsurance <i>(limited to 20 visits in a plan year)</i>	\$20 copay, non-PLUS deductible, and 20% coinsurance <i>(limited to 20 visits in a plan year)</i>
Diabetic supplies	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Dialysis	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Doctor visits (in person or virtual care)		
▪ Enhanced Personal Health Care PCP visits	\$15 copay	<i>Not applicable</i>
▪ Other PCP visits	\$20 copay	\$20 copay, non-PLUS deductible, and 20% coinsurance
▪ Specialist visits	\$30/60/75 copay	\$60 copay, non-PLUS deductible, and 20% coinsurance
▪ LiveHealth Online virtual care	\$15 copay	<i>Not applicable</i>

Service	Your member costs with PLUS providers	Your member costs with non-PLUS providers
Doctors – other services		
▪ At an emergency room	PLUS deductible	PLUS deductible
▪ Inpatient hospital care	PLUS deductible	Non-PLUS deductible and 20% coinsurance
▪ Outpatient hospital care	\$30/60/75 copay	\$60 copay, non-PLUS deductible, and 20% coinsurance
Drug screening (lab tests)	PLUS deductible	Non-PLUS deductible and 20% coinsurance
 Durable medical equipment (DME)	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Early intervention programs	No member costs	No member costs
Emergency room visits	\$100 copay and PLUS deductible	\$100 copay and PLUS deductible
 Enteral therapy	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Eye exams (routine)	\$30/60/75 copay (<i>limited to one exam every 24 months</i>)	\$60 copay and 20% coinsurance (<i>limited to one exam every 24 months</i>)
Eyeglasses and contact lenses	PLUS deductible and 20% coinsurance (<i>limited to the first lenses within six months after eye injury or cataract surgery</i>)	PLUS deductible and 20% coinsurance (<i>limited to the first lenses within six months after eye injury or cataract surgery</i>)
Family planning services	No member costs	No member costs
Fitness club 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 (<i>limited to \$2,000 for each impaired ear every 24 months</i>)	No member costs (<i>limited to \$2,000 for each impaired ear every 24 months</i>)
▪ Age 22 and over	No member costs for first \$500, then 20% coinsurance of the next \$1,500 (<i>up to a total benefit limit of \$1,700 every 24 months</i>)	No member costs for first \$500, then 20% coinsurance of the next \$1,500 (<i>up to a total benefit limit of \$1,700 every 24 months</i>)
Hearing exams	\$15/20/30/60/75 copay	\$20/60 copay, non-PLUS deductible, and 20% coinsurance
 High-tech imaging (e.g., MRIs, CT and PET scans)		
▪ Inpatient hospital	PLUS deductible	Non-PLUS deductible and 20% coinsurance
▪ Outpatient hospital and non-hospital-owned locations	\$100 daily copay and PLUS deductible	\$100 daily copay, non-PLUS deductible, and 20% coinsurance
 Home health care	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Home infusion therapy	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Hospice care	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Immunizations (vaccines)	No member costs (<i>you may have costs for an office visit</i>)	No member costs (<i>you may have costs for an office visit</i>)
 Inpatient services		
▪ At a hospital or rehab facility (semi-private room)	\$275/500/1,500 quarterly copay and PLUS deductible (\$500 copay outside of MA)	\$500 quarterly copay, non-PLUS deductible, and 20% coinsurance
▪ At a hospital or rehab facility (medically necessary private room)	<ul style="list-style-type: none"> ▪ First 90 days: \$275/500/1,500 quarterly copay and PLUS deductible (\$500 copay outside of MA) ▪ After 90 days: Dollar difference between the semi-private room rate and the private room rate 	<ul style="list-style-type: none"> ▪ First 90 days: \$500 quarterly copay, non-PLUS deductible, and 20% coinsurance ▪ After 90 days: 20% coinsurance, and the dollar difference between the semi-private room rate and the private room rate

Service	Your member costs with PLUS providers	Your member costs with non-PLUS providers
Inpatient services <i>(continued)</i> <ul style="list-style-type: none"> ▪ Neonatal ICU 	<ul style="list-style-type: none"> ▪ At a designated hospital: \$275 quarterly copay and PLUS deductible ▪ At other hospitals: \$275/500/1,500 quarterly copay and PLUS deductible (\$500 copay outside of MA) 	<ul style="list-style-type: none"> ▪ At a designated hospital: \$275 quarterly copay and PLUS deductible ▪ At other hospitals: \$500 quarterly copay, non-PLUS deductible, and 20% coinsurance
Lab services	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Occupational therapy	\$20 copay	\$20 copay and non-PLUS deductible
Office visits	<i>See “Doctor visits” on page 1.</i>	
Oxygen	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Personal Emergency Response Systems (PERS)		
<ul style="list-style-type: none"> ▪ Installation 	PLUS deductible and 20% coinsurance <i>(limited to \$50 in a plan year)</i>	PLUS deductible and 20% coinsurance <i>(limited to \$50 in a plan year)</i>
<ul style="list-style-type: none"> ▪ Rental 	PLUS deductible and 20% coinsurance <i>(limited to \$40 a month)</i>	PLUS deductible and 20% coinsurance <i>(limited to \$40 a month)</i>
Physical therapy	\$20 copay	\$20 copay and non-PLUS deductible
Prescription drugs	<ul style="list-style-type: none"> ▪ From a network pharmacy (30-day supply): \$10/30/65 copay ▪ By mail order (90-day supply): \$25/75/165 <p style="text-align: center;"><i>These benefits are administered by Express Scripts. Call 855-283-7679 for information.</i></p>	
Preventive care	No member costs	No member costs
Private duty nursing in a home setting	PLUS deductible and 20% coinsurance <i>(limited to \$8,000 in a plan year)</i>	Non-PLUS deductible and 20% coinsurance <i>(limited to \$8,000 in a plan year)</i>
Prosthetics and orthotics		
<ul style="list-style-type: none"> ▪ Breast prosthetics 	PLUS deductible	Non-PLUS deductible
<ul style="list-style-type: none"> ▪ Other prosthetics and orthotics 	PLUS deductible and 20% coinsurance	Non-PLUS deductible and 20% coinsurance
Radiation therapy	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Radiology (e.g., X-rays)		
<ul style="list-style-type: none"> ▪ Inpatient hospital 	PLUS deductible	Non-PLUS deductible and 20% coinsurance
<ul style="list-style-type: none"> ▪ Outpatient hospital and non-hospital-owned locations 	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Retail health clinic visits	\$20 copay	\$20 copay
Skilled nursing and long-term care facilities	PLUS deductible and 20% coinsurance <i>(limited to 45 days in a plan year)</i>	PLUS deductible and 20% coinsurance <i>(limited to 45 days in a plan year)</i>
Sleep studies	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Speech therapy		
<ul style="list-style-type: none"> ▪ With an autism diagnosis 	No member costs	Non-PLUS deductible and 20% coinsurance
<ul style="list-style-type: none"> ▪ All other speech therapy 	No member costs <i>(limited to 20 visits in a plan year)</i>	Non-PLUS deductible and 20% coinsurance <i>(limited to 20 visits in a plan year)</i>

Service	Your member costs with PLUS providers	Your member costs with non-PLUS providers
📞 Surgery		
▪ Inpatient hospital	PLUS deductible <i>(you also have an inpatient copay; see “Inpatient services”)</i>	Non-PLUS deductible and 20% coinsurance <i>(you also have an inpatient copay; see “Inpatient services”)</i>
▪ Outpatient hospital	\$110/110/250 quarterly copay and PLUS deductible (\$110 copay outside of MA)	\$110 quarterly copay, non-PLUS deductible, and 20% coinsurance
▪ Non-hospital-owned locations	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Tobacco cessation counseling	No member costs <i>(limited to 300 minutes in a plan year)</i>	No member costs <i>(limited to 300 minutes in a plan year)</i>
📞 Transplants		
▪ At a Quality Center or Designated Hospital for transplants	\$275/500/1,500 quarterly copay and PLUS deductible	\$275/500/1,500 quarterly copay and PLUS deductible
▪ At other hospitals	\$275/500/1,500 quarterly copay, PLUS deductible, and 20% coinsurance	\$500 quarterly copay, non-PLUS deductible, and 20% coinsurance
Urgent care center visits	\$20 copay	\$20 copay
Virtual care (telehealth)	See “Doctor visits” on page 1.	
Wigs (after cancer treatment)	20% coinsurance	20% coinsurance

Benefits for behavioral health care under PLUS

Service	Your member costs with PLUS providers	Your member costs with non-PLUS providers
Emergency service programs	No member costs	No member costs
📞 Inpatient care		
▪ Facility charges	\$200 quarterly copay	\$200 quarterly copay, non-PLUS deductible, and 20% coinsurance
▪ Professional services	No member costs	Non-PLUS deductible and 20% coinsurance
Medication-assisted treatment	No member costs	No member costs
Medication management	\$15 copay	\$20 copay and non-PLUS deductible
📞 Office services	\$15 copay	\$20 copay and non-PLUS deductible
📞 Outpatient services	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Substance use disorder assessment / referral	No member costs	No member costs
Therapy		
▪ Individual therapy	\$15 copay	\$20 copay and non-PLUS deductible
▪ Family therapy	\$15 copay	\$20 copay and non-PLUS deductible
▪ Group therapy	\$15 copay	\$20 copay and non-PLUS deductible
Virtual care (telehealth) <i>When using LiveHealth Online or a PLUS provider, you don't owe a copay for the first three visits.</i>	<ul style="list-style-type: none"> ▪ LiveHealth Online: \$15 copay ▪ Other PLUS providers: Copay of the service being provided 	Non-PLUS copay, deductible, and coinsurance of the service being provided