PLAN BENEFITS – PLUS

For UniCare State Indemnity Plan/PLUS members

Effective July 1, 2019

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. A separate non-PLUS deductible of $500 per person or $1,000 for a family applies to services from 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 the PLUS plan

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 and 20% coinsurance
Bereavement counseling	PLUS deductible and 20% coinsurance *(limited to $1,500 for a family in a plan year)*	Non-PLUS deductible and 20% coinsurance *(limited to $1,500 for a family a plan year)*
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 *(limited to 20 visits in a plan year)*	$20 copay, non-PLUS deductible, and 20% coinsurance *(limited to 20 visits in a plan year)*
Diabetic supplies	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Dialysis	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Doctors – office visits		
▪ Patient-centered primary care PCP visits	$15 copay	*Not applicable*
▪ 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
▪ Telehealth (LiveHealth Online)	$15 copay	*Not applicable*
Doctors – other		
▪ Emergency room care	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

Service	Your member costs with PLUS providers	Your member costs with non-PLUS providers
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	$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 *(limited to one exam every 24 months)*	$60 copay and 20% coinsurance *(limited to one exam every 24 months)*
Eyeglasses and contact lenses	PLUS deductible and 20% coinsurance *(limited to the first lenses within six months after eye injury or cataract surgery)*	PLUS 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 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 *(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 limit of $1,700 every 24 months)*	No member costs for first $500, then 20% coinsurance of the next $1,500 *(up to a limit of $1,700 every 24 months)*
Hearing exams	$15/20/30/60/75 copay	$20/60 copay, non-PLUS deductible, and 20% coinsurance
☎ **High-tech imaging (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 *(you may have costs for an office visit)*	No member costs *(you may have costs for an office visit)*
☎ **Inpatient hospital care** ▪ At a hospital or rehab facility (semi-private room)	$275/500/1,500 quarterly copay and PLUS deductible	$500 quarterly copay, non-PLUS deductible, and 20% coinsurance
▪ At a hospital or rehab facility (medically necessary private room)	▪ **First 90 days:** $275/500/1,500 quarterly copay and PLUS deductible ▪ **After 90 days:** Dollar difference between the semi-private room rate and the private room rate	▪ **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 hospital care** ***(cont.)***		
▪ Neonatal ICU	▪ **At a designated hospital:** $275 quarterly copay and PLUS deductible ▪ **At other hospitals:** $275/500/1,500 quarterly copay and PLUS deductible	▪ **At a designated hospital:** $275 quarterly copay and PLUS deductible ▪ **At other hospitals:** $500 quarterly copay, non-PLUS deductible, and 20% coinsurance
▪ At a skilled nursing or long-term care facility	PLUS deductible and 20% coinsurance *(limited to 45 days in a plan year)*	PLUS deductible and 20% coinsurance *(limited to 45 days in a plan year)*
Lab services	PLUS deductible	Non-PLUS deductible and 20% coinsurance
☎ **Occupational therapy**	$20 copay	$20 copay and non-PLUS deductible
Office visits		
▪ Patient-centered primary care PCP visits	$15 copay	*Not applicable*
▪ 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
▪ Telehealth (LiveHealth Online)	$15 copay	*Not applicable*
Oxygen	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Personal Emergency Response Systems (PERS)		
▪ Installation	PLUS deductible and 20% coinsurance *(limited to $50 in a plan year)*	PLUS deductible and 20% coinsurance *(limited to $50 in a plan year)*
▪ Rental	PLUS deductible and 20% coinsurance *(limited to $40 a month)*	PLUS deductible and 20% coinsurance *(limited to $40 a month)*
☎ **Physical therapy**	$20 copay	$20 copay and non-PLUS deductible
Prescription drugs	Benefits 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**	PLUS deductible and 20% coinsurance *(limited to $8,000 in a plan year)*	Non-PLUS deductible and 20% coinsurance *(limited to $8,000 in a plan year)*
Prosthetics and orthotics		
▪ Breast prosthetics	PLUS deductible	Non-PLUS deductible
▪ 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		
▪ Inpatient hospital	PLUS deductible	Non-PLUS deductible and 20% coinsurance
▪ Outpatient hospital and non-hospital-owned locations	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Retail health clinic visits	$20 copay	$20 copay
☎ **Sleep studies**	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Speech therapy	No member costs *(limited to 20 visits in a plan year)*	Non-PLUS deductible and 20% coinsurance *(limited to 20 visits in a plan year)*

Service	Your member costs with PLUS providers	Your member costs with non-PLUS providers
☎ **Surgery**		
▪ Inpatient hospital	PLUS deductible *(you also have an inpatient hospital copay; see "Inpatient hospital care")*	Non-PLUS deductible and 20% coinsurance *(you also have an inpatient hospital copay; see "Inpatient hospital care")*
▪ Outpatient hospital	$110/110/250 quarterly copay and PLUS deductible	$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 *(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	$275/500/1,500 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
Wigs (after cancer treatment)	20% coinsurance	20% coinsurance

Benefits for behavioral health care under the PLUS plan

Behavioral health benefits are higher when you get your behavioral health care from providers in the Beacon Health Options network.

Service	Your member costs with in-network providers	Your member costs with out-of-network providers
☎ **Acute care services**	$200 quarterly copay	$200 quarterly copay, non-PLUS deductible, and 20% coinsurance
Emergency care		
▪ Hospital emergency room	$100 copay and PLUS deductible	$100 copay and PLUS deductible
▪ Emergency service programs	No member costs	No member costs
Medication management	$15 copay	$30 copay and non-PLUS deductible
Methadone maintenance	No member costs	No member costs
☎ **Outpatient services**	$20 copay	$30 copay and non-PLUS deductible
Substance use disorder assessment / referral	No member costs	No member costs
Telehealth (LiveHealth Online)	$15 copay	Not covered
Therapy		
▪ Family therapy	$20 copay	$30 copay and non-PLUS deductible
▪ Group therapy	$15 copay	$30 copay and non-PLUS deductible
▪ Individual therapy	$20 copay	$30 copay and non-PLUS deductible

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