

PLAN BENEFITS – COMMUNITY CHOICE

For UniCare State Indemnity Plan/Community Choice members

Effective July 1, 2019






Summary of Community Choice benefits







This summary shows Community Choice 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 Community Choice plan deductible is \$400 for one person or \$800 for a family each plan year.
- ❑ **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 Community Choice

Service	Your member costs
Ambulances	Deductible
Anesthesia	Deductible
Bereavement counseling	Deductible and 20% coinsurance (<i>limited to \$1,500 for a family in a plan year</i>)
Cardiac rehab programs	Deductible
Chemotherapy	Deductible
☎ Chiropractic care	\$15 copay and 20% coinsurance (<i>limited to 20 visits in a plan year</i>)
Diabetic supplies	<ul style="list-style-type: none"> ▪ Preferred vendors: Deductible ▪ Non-preferred vendors: Deductible and 20% coinsurance
Dialysis	Deductible
Doctors – office visits	
▪ Patient-centered primary care PCP visits	\$15 copay
▪ Other PCP visits	\$20 copay
▪ Specialist visits	\$30/60/75 copay
▪ Telehealth (LiveHealth Online)	\$15 copay
Doctors – other	
▪ Emergency room care	Deductible
▪ Inpatient hospital care	Deductible
▪ Outpatient hospital care	\$30/60/75 copay
Drug screening (lab tests)	
▪ Hospital outpatient	<ul style="list-style-type: none"> ▪ Community Choice – Deductible ▪ Non-Community Choice – \$50 daily copay and deductible
▪ Non-hospital-owned lab	Deductible

Service	Your member costs
 Durable medical equipment (DME)	<ul style="list-style-type: none"> ▪ Preferred vendors: Deductible ▪ Non-preferred vendors: Deductible and 20% coinsurance
Early intervention programs	No member costs
Emergency room	\$100 copay and deductible
 Enteral therapy	<ul style="list-style-type: none"> ▪ Preferred vendors: Deductible ▪ Non-preferred vendors: Deductible and 20% coinsurance
Eye exams (routine)	\$30/60/75 copay <i>(limited to one exam every 24 months)</i>
Eyeglasses and contact lenses	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
Fitness club reimbursement	Reimbursed up to \$100 for the family in a plan year
Hearing aids <ul style="list-style-type: none"> ▪ Age 21 and under ▪ Age 22 and over 	No member costs <i>(limited to \$2,000 for each impaired ear every 24 months)</i> No member costs for first \$500, then 20% coinsurance of the next \$1,500 <i>(up to a limit of \$1,700 every 24 months)</i>
Hearing exams	\$15/20/30/60/75 copay
 High-tech imaging (MRIs, CT and PET scans) <ul style="list-style-type: none"> ▪ Inpatient hospital ▪ Outpatient hospital ▪ Non-hospital-owned location 	<ul style="list-style-type: none"> ▪ Community Choice – Deductible ▪ Non-Community Choice – Deductible and 20% coinsurance ▪ Community Choice – \$100 daily copay and deductible ▪ Non-Community Choice – \$200 daily copay and deductible ▪ \$100 daily copay and deductible
 Home health care	<ul style="list-style-type: none"> ▪ Preferred vendors: Deductible ▪ Non-preferred vendors: Deductible and 20% coinsurance
Home infusion therapy	<ul style="list-style-type: none"> ▪ Preferred vendors: Deductible ▪ Non-preferred vendors: Deductible and 20% coinsurance
Hospice care	Deductible
Immunizations (vaccines)	No member costs <i>(you may have costs for an office visit)</i>
 Inpatient hospital care <ul style="list-style-type: none"> ▪ At a hospital or rehab facility (semi-private room) ▪ At a hospital or rehab facility (medically necessary private room) 	<ul style="list-style-type: none"> ▪ Community Choice – \$275 quarterly copay and deductible ▪ Non-Community Choice – \$750 per-admission copay, deductible, and 20% coinsurance ▪ Community Choice: <ul style="list-style-type: none"> ▪ First 90 days: \$275 quarterly copay and deductible ▪ After 90 days: Dollar difference between the semi-private room rate and the private room rate ▪ Non-Community Choice <ul style="list-style-type: none"> ▪ First 90 days: \$750 per-admission copay, 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
 Inpatient hospital care (cont.) <ul style="list-style-type: none"> ▪ Neonatal ICU 	<ul style="list-style-type: none"> ▪ Community Choice – \$275 quarterly copay and deductible ▪ Non-Community Choice <ul style="list-style-type: none"> ▪ At a designated hospital: \$275 quarterly copay and deductible ▪ At other hospitals: \$750 per-admission copay, deductible, and 20% coinsurance
<ul style="list-style-type: none"> ▪ Skilled nursing or long-term care facility 	Deductible and 20% coinsurance <i>(limited to 45 days in a plan year)</i>
Lab services <ul style="list-style-type: none"> ▪ Inpatient hospital 	<ul style="list-style-type: none"> ▪ Community Choice – Deductible ▪ Non-Community Choice – Deductible and 20% coinsurance
<ul style="list-style-type: none"> ▪ Outpatient hospital 	<ul style="list-style-type: none"> ▪ Community Choice – Deductible ▪ Non-Community Choice – \$50 daily copay and deductible
<ul style="list-style-type: none"> ▪ Non-hospital-owned locations 	Deductible
 Occupational therapy	\$15 copay
Office visits <ul style="list-style-type: none"> ▪ Patient-centered primary care PCP visits 	\$15 copay
<ul style="list-style-type: none"> ▪ Other PCP visits 	\$20 copay
<ul style="list-style-type: none"> ▪ Specialist visits 	\$30/60/75 copay
<ul style="list-style-type: none"> ▪ Telehealth (LiveHealth Online) 	\$15 copay
Oxygen	<ul style="list-style-type: none"> ▪ Preferred vendors: Deductible ▪ Non-preferred vendors: Deductible and 20% coinsurance
Personal Emergency Response Systems (PERS) <ul style="list-style-type: none"> ▪ Installation 	Deductible and 20% coinsurance <i>(limited to \$50 in a plan year)</i>
<ul style="list-style-type: none"> ▪ Rental 	Deductible and 20% coinsurance <i>(limited to \$40 a month)</i>
 Physical therapy	\$15 copay
Prescription drugs	Benefits administered by Express Scripts. Call 855-283-7679 for information.
Preventive care	No member costs
 Private duty nursing in a home setting	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 	Deductible
<ul style="list-style-type: none"> ▪ Other prosthetics and orthotics 	Deductible and 20% coinsurance
 Radiation therapy	Deductible
Radiology <ul style="list-style-type: none"> ▪ Inpatient hospital 	<ul style="list-style-type: none"> ▪ Community Choice – Deductible ▪ Non-Community Choice – Deductible and 20% coinsurance
<ul style="list-style-type: none"> ▪ Outpatient hospital 	<ul style="list-style-type: none"> ▪ Community Choice – Deductible ▪ Non-Community Choice – \$50 daily copay and deductible
<ul style="list-style-type: none"> ▪ Non-hospital-owned locations 	Deductible
Retail health clinic visits	\$20 copay
 Sleep studies	<ul style="list-style-type: none"> ▪ Community Choice – Deductible ▪ Non-Community Choice – \$50 daily copay and deductible

Service	Your member costs
Speech therapy	No member costs <i>(limited to 20 visits in a plan year)</i>
📞 Surgery	
▪ Inpatient hospital	<ul style="list-style-type: none"> ▪ Community Choice – Deductible <i>(you also have an inpatient hospital copay; see “Inpatient hospital care”)</i> ▪ Non-Community Choice – Deductible and 20% coinsurance <i>(you also have an inpatient hospital copay; see “Inpatient hospital care”)</i>
▪ Outpatient hospital	<ul style="list-style-type: none"> ▪ Community Choice – \$110 quarterly copay and deductible ▪ Non-Community Choice – \$250 per-visit copay, deductible, and 20% coinsurance
▪ Non-hospital-owned locations	Deductible
Tobacco cessation counseling	No member costs <i>(limited to 300 minutes in a plan year)</i>
📞 Transplants	
▪ At a Quality Center or Designated Hospital for transplants	\$275 quarterly copay and deductible
▪ At other hospitals	<ul style="list-style-type: none"> ▪ Community Choice – \$275 quarterly copay, deductible, and 20% coinsurance ▪ Non-Community Choice – \$750 per-admission copay, deductible, and 20% coinsurance
Urgent care center visits	\$20 copay
Wigs (after cancer treatment)	20% coinsurance

Benefits for behavioral health care under Community Choice

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 and deductible
Emergency care		
▪ Hospital emergency room	\$100 copay and deductible	\$100 copay and deductible
▪ Emergency service programs	No member costs	No member costs
Medication management	\$15 copay	\$30 copay and deductible
Methadone maintenance	No member costs	No member costs
📞 Outpatient services	\$20 copay	\$30 copay and 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 deductible
▪ Group therapy	\$15 copay	\$30 copay and deductible
▪ Individual therapy	\$20 copay	\$30 copay and deductible