

# PLAN BENEFITS – BASIC

For UniCare State Indemnity Plan/Basic members

Effective July 1, 2018

## 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.
- ❑ **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 Basic plan

Service	Your member costs with CIC	Your member costs without CIC
<b>Ambulances</b>	Deductible	Deductible
<b>Anesthesia</b>	Deductible	Deductible and 20% coinsurance
<b>Bereavement counseling</b>	Deductible and 20% coinsurance ( <i>limited to \$1,500 for a family in a plan year</i> )	Deductible and 20% coinsurance ( <i>limited to \$1,500 for a family in a plan year</i> )
<b>Cardiac rehab programs</b>	Deductible	Deductible
<b>Chemotherapy</b>	Deductible	Deductible and 20% coinsurance
📞 <b>Chiropractic care</b>	\$20 copay and 20% coinsurance ( <i>limited to 20 visits in a plan year</i> )	\$20 copay and 20% coinsurance ( <i>limited to 20 visits in a plan year</i> )
<b>Diabetic supplies</b>	<ul style="list-style-type: none"> <li>▪ <b>Preferred vendors:</b> Deductible</li> <li>▪ <b>Non-preferred vendors:</b> Deductible and 20% coinsurance</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>Preferred vendors:</b> Deductible</li> <li>▪ <b>Non-preferred vendors:</b> Deductible and 20% coinsurance</li> </ul>
<b>Dialysis</b>	Deductible	Deductible and 20% coinsurance
<b>Doctors – office visits</b>		
▪ Primary care (PCP) visits	\$20 copay	\$20 copay and 20% coinsurance
▪ Specialist visits	\$30/60/75 copay	\$30/60/75 copay and 20% coinsurance
▪ LiveHealth Online telehealth	\$15 copay	\$15 copay and 20% coinsurance
<b>Doctors – other</b>		
▪ Emergency room care	Deductible	Deductible and 20% coinsurance
▪ Inpatient hospital care	Deductible	Deductible and 20% coinsurance
▪ Outpatient hospital care	\$30/60/75 copay	\$30/60/75 copay and 20% coinsurance
<b>Drug screening (lab tests)</b>	Deductible	Deductible
📞 <b>Durable medical equipment (DME)</b>	<ul style="list-style-type: none"> <li>▪ <b>Preferred vendors:</b> Deductible</li> <li>▪ <b>Non-preferred vendors:</b> Deductible and 20% coinsurance</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>Preferred vendors:</b> Deductible</li> <li>▪ <b>Non-preferred vendors:</b> Deductible and 20% coinsurance</li> </ul>

PLAN BENEFITS – BASIC (continued)

Service	Your member costs with CIC	Your member costs without CIC
<b>Early intervention programs</b>	No member costs	No member costs
<b>Emergency room</b>	\$100 copay and deductible	\$100 copay and deductible
 <b>Enteral therapy</b>	<ul style="list-style-type: none"> <li>▪ <b>Preferred vendors:</b> Deductible</li> <li>▪ <b>Non-preferred vendors:</b> Deductible and 20% coinsurance</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>Preferred vendors:</b> Deductible</li> <li>▪ <b>Non-preferred vendors:</b> Deductible and 20% coinsurance</li> </ul>
<b>Eye exams (routine)</b>	\$30/60/75 copay (limited to one exam every 24 months)	\$30/60/75 copay (limited to one exam every 24 months)
<b>Eyeglasses and contact lenses</b>	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)
<b>Family planning services</b>	No member costs	No member costs
<b>Fitness club reimbursement</b>	Reimbursed up to \$100 for the family in a plan year	Reimbursed up to \$100 for the family in a plan year
<b>Hearing aids</b>		
▪ 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)
<b>Hearing exams</b>	\$20/30/60/75 copay	\$20/30/60/75 copay and 20% coinsurance
 <b>Home health care</b>	<ul style="list-style-type: none"> <li>▪ <b>Preferred vendors:</b> Deductible</li> <li>▪ <b>Non-preferred vendors:</b> Deductible and 20% coinsurance</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>Preferred vendors:</b> Deductible</li> <li>▪ <b>Non-preferred vendors:</b> Deductible and 20% coinsurance</li> </ul>
<b>Home infusion therapy</b>	<ul style="list-style-type: none"> <li>▪ <b>Preferred vendors:</b> Deductible</li> <li>▪ <b>Non-preferred vendors:</b> Deductible and 20% coinsurance</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>Preferred vendors:</b> Deductible</li> <li>▪ <b>Non-preferred vendors:</b> Deductible and 20% coinsurance</li> </ul>
<b>Hospice care</b>	Deductible	Deductible
<b>Immunizations (vaccines)</b>	No member costs (you may have costs for an office visit)	No member costs (you may have costs for an office visit)
 <b>Inpatient hospital care</b>		
▪ At a hospital or rehab facility (semi-private room)	\$275 quarterly copay and deductible	<ul style="list-style-type: none"> <li>▪ <b>First 120 days:</b> \$300 quarterly copay and deductible</li> <li>▪ <b>After 120 days:</b> 20% coinsurance</li> </ul>
▪ At a hospital or rehab facility (medically necessary private room)	<ul style="list-style-type: none"> <li>▪ <b>First 90 days:</b> \$275 quarterly copay and deductible</li> <li>▪ <b>After 90 days:</b> Dollar difference between the semi-private room rate and the private room rate</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>First 90 days:</b> \$300 quarterly copay and deductible</li> <li>▪ <b>Days 91 to 120:</b> Dollar difference between the semi-private room rate and the private room rate</li> <li>▪ <b>After 120 days:</b> 20% coinsurance and the dollar difference between the semi-private room rate and the private room rate</li> </ul>
▪ At a skilled nursing or long-term care facility	Deductible and 20% coinsurance (limited to 45 days in a plan year)	Deductible and 20% coinsurance (limited to 45 days in a plan year)

Service	Your member costs with CIC	Your member costs without CIC
<b>Lab services</b>	Deductible	Deductible
 <b>Occupational therapy</b>	\$20 copay	\$20 copay
<b>Office visits</b>		
▪ Primary care (PCP) visits	\$20 copay	\$20 copay and 20% coinsurance
▪ Specialist visits	\$30/60/75 copay	\$30/60/75 copay and 20% coinsurance
▪ LiveHealth Online telehealth	\$15 copay	\$15 copay and 20% coinsurance
<b>Oxygen</b>	<ul style="list-style-type: none"> <li>▪ <b>Preferred vendors:</b> Deductible</li> <li>▪ <b>Non-preferred vendors:</b> Deductible and 20% coinsurance</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>Preferred vendors:</b> Deductible</li> <li>▪ <b>Non-preferred vendors:</b> Deductible and 20% coinsurance</li> </ul>
<b>Personal Emergency Response Systems (PERS)</b>		
▪ Installation	Deductible and 20% coinsurance <i>(limited to \$50 in a plan year)</i>	Deductible and 20% coinsurance <i>(limited to \$50 in a plan year)</i>
▪ Rental	Deductible and 20% coinsurance <i>(limited to \$40 a month)</i>	Deductible and 20% coinsurance <i>(limited to \$40 a month)</i>
 <b>Physical therapy</b>	\$20 copay	\$20 copay
<b>Prescription drugs</b>	Benefits administered by Express Scripts. Call 855-283-7679 for information.	
<b>Preventive care</b>	No member costs	No member costs
 <b>Private duty nursing in a home setting</b>	Deductible and 20% coinsurance <i>(limited to \$8,000 in a plan year)</i>	Deductible and 20% coinsurance <i>(limited to \$4,000 in a plan year)</i>
<b>Prosthetics and orthotics</b>		
▪ Breast prosthetics	Deductible	Deductible
▪ Other prosthetics and orthotics	Deductible and 20% coinsurance	Deductible and 20% coinsurance
 <b>Radiation therapy</b>	Deductible	Deductible and 20% coinsurance
<b>Radiology and imaging</b>		
▪ Inpatient hospital	Deductible	Deductible
▪  High-tech imaging – outpatient hospital and non-hospital-owned location (MRIs, CT and PET scans)	\$100 daily copay and deductible	\$100 daily copay, deductible, and 20% coinsurance
▪ Other radiology – outpatient hospital and non-hospital-owned locations	Deductible	Deductible and 20% coinsurance
<b>Retail health clinic visits</b>	\$20 copay	\$20 copay and 20% coinsurance
 <b>Sleep studies</b>	Deductible	Deductible and 20% coinsurance
<b>Speech therapy</b>	No member costs <i>(limited to 20 visits in a plan year)</i>	20% coinsurance <i>(limited to 20 visits in a plan year)</i>
 <b>Surgery</b>		
▪ Inpatient hospital	Deductible <i>(you also have an inpatient hospital copay)</i>	Deductible and 20% coinsurance <i>(you also have an inpatient hospital copay)</i>
▪ Outpatient hospital	\$250 quarterly copay and deductible	\$250 quarterly copay, deductible, and 20% coinsurance
▪ Non-hospital-owned location	Deductible	Deductible and 20% coinsurance

Service	Your member costs with CIC	Your member costs without CIC
<b>Tobacco cessation counseling</b>	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> )
<b>Transplants</b>		
▪ 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
<b>Urgent care center visits</b>	\$20 copay	\$20 copay and 20% coinsurance
<b>Wigs (after cancer treatment)</b>	20% coinsurance	20% coinsurance

## Benefits for behavioral health care under the Basic 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
<b>Acute care services</b>	\$150 quarterly copay	\$200 quarterly copay and deductible
<b>Emergency care</b>		
▪ Hospital emergency room	\$100 copay and deductible	\$100 copay and deductible
▪ Emergency service programs	No member costs	No member costs
<b>LiveHealth Online telehealth</b>	\$15 copay	Not covered
<b>Medication management</b>	\$15 copay	\$30 copay and deductible
<b>Methadone maintenance</b>	No member costs	No member costs
<b>Outpatient services</b>	\$20 copay	\$30 copay and deductible
<b>Substance use disorder assessment / referral</b>	No member costs	No member costs
<b>Therapy</b>		
▪ Family therapy	\$20 copay	\$30 copay and deductible
▪ Group therapy	\$15 copay	\$30 copay and deductible
▪ Individual therapy	\$20 copay	\$30 copay and deductible



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