

Copay Amounts for Comprehensive Eye Exam
(Brookline GIC Insurance Carriers as of 3/28/2017)

Plan Name	Copay Amount
Fallon Community Health Plan Direct Care	\$15
Fallon Community Health Plan Select Care	\$20
Harvard Pilgrim Independence Plan	\$20
Harvard Pilgrim Primary Choice	\$20
Health New England	\$20
NHP Care (Neighborhood Health Plan)	\$60
Tufts Health Plan Navigator (thru EyeMed)	\$20
Tufts Health Plan Spirit (thru EyeMed)	\$20
Unicare State Indemnity Plan/Basic with CIC	\$60
Unicare State Indemnity Plan/Community Choice	\$60
Unicare State Indemnity Plan/PLUS	\$60

Town of Brookline
Group Health Insurance Rates
ACTIVE EMPLOYEES AND NON-MEDICARE ELIGIBLE RETIREES
Effective July 1, 2016

Plan	Total Annual Premium	Total Monthly Premium	Town Share Monthly	Employee Monthly	Town/School Employee Weekly (52)	School Employee Weekly (41)	School Employee Bi-Weekly (21)
Fallon Community Health Plan Direct Care	\$6,236.88 \$14,968.80	\$519.74 \$1,247.40	\$431.38 \$1,035.34	\$88.36 \$212.06	\$20.39 \$48.94	\$25.86 \$62.07	\$50.49 \$121.18
Fallon Community Health Plan Select Care	\$8,287.92 \$19,890.48	\$690.66 \$1,657.54	\$573.25 \$1,375.76	\$117.41 \$281.78	\$27.10 \$65.03	\$34.36 \$82.47	\$67.09 \$161.02
Harvard Pilgrim Independence Plan	\$9,797.16 \$23,904.84	\$816.43 \$1,992.07	\$677.64 \$1,653.42	\$138.79 \$338.65	\$32.03 \$78.15	\$40.62 \$99.12	\$79.31 \$193.52
Harvard Pilgrim Primary Choice	\$7,324.80 \$17,872.56	\$610.40 \$1,489.38	\$506.63 \$1,236.19	\$103.77 \$253.19	\$23.95 \$58.43	\$30.37 \$74.11	\$59.30 \$144.68
Health New England	\$6,418.44 \$15,912.48	\$534.87 \$1,326.04	\$443.94 \$1,100.61	\$90.93 \$225.43	\$20.98 \$52.02	\$26.61 \$65.98	\$51.96 \$128.82
NHP Care (Neighborhood Health Plan)	\$6,146.52 \$16,287.84	\$512.21 \$1,357.32	\$425.13 \$1,126.58	\$87.08 \$230.74	\$20.09 \$53.25	\$25.49 \$67.53	\$49.76 \$131.85
Tufts Health Plan Navigator	\$8,236.08 \$20,096.16	\$686.34 \$1,674.68	\$569.66 \$1,389.98	\$116.68 \$284.70	\$26.93 \$65.70	\$34.15 \$83.33	\$66.67 \$162.68
Tufts Health Plan Sprint	\$6,183.84 \$14,886.24	\$515.32 \$1,240.52	\$427.72 \$1,029.63	\$87.60 \$210.89	\$20.22 \$48.67	\$25.64 \$61.72	\$50.06 \$120.51

Town of Brookline
Group Health Insurance Rates
ACTIVE EMPLOYEES AND NON-MEDICARE ELIGIBLE RETIREES
Effective July 1, 2016

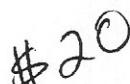
Plan	Total Annual Premium	Total Monthly Premium	Town Share Monthly	Employee Monthly	Town/School Employee Weekly (52)	School Employee Weekly (41)	School Employee Bi-Weekly (21)
Unicare State Indemnity Plan/Basic with CIC*							
Individual	\$12,028.92	\$1,002.41	\$651.57	\$350.84	\$80.96	\$102.69	\$200.48
Family	\$28,157.28	\$2,346.44	\$1,525.19	\$821.25	\$189.52	\$240.37	\$469.29
Unicare State Indemnity Plan/Basic-without CIC*							
Individual	\$11,509.08	\$957.09	\$623.41	\$339.68	\$74.46	\$94.25	\$188.22
Family	\$26,951.52	\$2,245.96	\$1,459.87	\$860.00	\$181.40	\$230.87	\$449.19
Unicare State Indemnity Plan/Community Choice							
Individual	\$5,851.56	\$487.63	\$404.73	\$82.90	\$19.13	\$24.26	\$47.37
Family	\$14,044.20	\$1,170.35	\$971.39	\$198.96	\$45.91	\$58.23	\$113.69
Unicare State Indemnity Plan/PLUS							
Individual	\$7,863.84	\$655.32	\$543.92	\$111.40	\$25.71	\$32.61	\$63.66
Family	\$18,793.56	\$1,566.13	\$1,299.89	\$266.24	\$61.44	\$77.92	\$152.14
Delta Dental Low Option (Active Employees Only)							
Individual	\$197.76	\$16.48	\$0	\$16.48	\$3.80	\$4.82	\$9.42
Individual +1	\$395.52	\$32.96	\$0	\$32.96	\$7.61	\$9.65	\$18.83
Family	\$654.48	\$54.54	\$0	\$54.54	\$12.59	\$15.96	\$31.17
Delta Dental High Option (Active Employees Only)							
Individual	\$656.16	\$54.68	\$0	\$54.68	\$12.62	\$16.00	\$31.25
Individual +1	\$1,191.00	\$99.25	\$0	\$99.25	\$22.90	\$29.05	\$56.71
Family	\$1,871.04	\$155.92	\$0	\$155.92	\$35.98	\$45.64	\$89.10
Life Insurance							
AFSCME Professional Life Insurance (Active Only)	\$76.20	\$6.35	\$4.76	\$1.59	\$0.37	\$0.46	\$0.91
	\$5.16	\$0.43	\$0.00	\$0.43	\$0.10	N/A	

1. School Professionals [Teachers] and Paraprofessionals [Teacher's Aides] are paid on a bi-weekly basis. This deduction rate is based on 12 months of benefit premiums divided equally over 21 payroll deductions. Any new employees with an insurance effective date other than Sept 1st and/or receives their first paycheck after the first school payroll will have an adjusted deduction rate in the first 2 - 4 pay checks.

2. School employees who are paid weekly but fewer than 52 weeks per year will have 41 benefit deductions withheld from their pay.

*For FY16, the Town will pay 83% of the premium and the employee/retiree pays 35% of the premium.

Covered services	Benefits
Preventive care <ol style="list-style-type: none"> 1. Routine physical exams for the prevention and detection of disease 2. Immunizations that are included on the formulary, that are for covered medical benefits and that are ordered, supplied and administered by a plan physician. If administered by a plan specialist, you will generally need to obtain a referral to see the specialist. 3. A baseline mammogram for women age 35 to 40, and a yearly mammogram for women age 40 and older 4. Routine gynecological care services, including an annual Pap smear (cytological screening) and pelvic exam 	Covers in full Covers in full Covers in full Covers in full
5. Routine eye exams, once in each 24-month period	\$15 copayment per visit 
6. Hearing and vision screening 7. Well-child care and pediatric services, at least six times during the child's first year after birth, at least three times during the next year, then at least annually until the child's sixth birthday. This includes the following services, as recommended by the physician and in accordance with state law: <ul style="list-style-type: none"> • physical examination • history • measurements • sensory screening • neuropsychiatric evaluation • development screening and assessment 	Covers in full Covers in full \$15
8. Pediatric services including: <ul style="list-style-type: none"> • appropriate immunizations • hereditary and metabolic screening at birth • newborn hearing screening test performed before the newborn infant is discharged from the hospital or birthing center • tuberculin tests, hematocrit, hemoglobin, and other appropriate blood tests and urinalysis • lead screening 	Covers in full
9. Female consultations, examinations, procedures, contraceptive devices, and medical services related to the use of all contraceptive methods*	Covers in full
* Prescription contraceptive devices are covered under the prescription drug benefit.	
Reconstructive surgery <i>Referral and prior authorization required (unless provided by a Reliant Medical Group specialist and you have a Reliant Medical Group PCP)</i> <ol style="list-style-type: none"> 1. Inpatient hospital services including room and board in a semiprivate room and the services and supplies that would ordinarily be furnished to you while you are an inpatient, including Massachusetts mandated services for cleft lip and cleft palate 	\$275 copayment per admission then subject to your deductible (you are responsible for up to one copayment per member per calendar quarter)

Covered services	Benefits
Preventive care	
1. Routine physical exams for the prevention and detection of disease	Covered in full
2. Immunizations that are included on the formulary, that are for covered medical benefits and that are ordered, supplied and administered by a plan physician. If administered by a plan specialist, you will generally need to obtain a referral to see the specialist.	Covered in full
3. A baseline mammogram for women age 35 to 40, and a yearly mammogram for women age 40 and older	Covered in full
4. Routine gynecological care services, including an annual Pap smear (cytological screening) and pelvic exam	Covered in full
5. Routine eye exams, once in each 24-month period	\$20 copayment per visit 
6. Hearing and vision screening	Covered in full
7. Well-child care and pediatric services, at least six times during the child's first year after birth, at least three times during the next year, then at least annually until the child's sixth birthday. This includes the following services, as recommended by the physician and in accordance with state law: <ul style="list-style-type: none"> • physical examination • history • measurements • sensory screening • neuropsychiatric evaluation • development screening and assessment 	Covered in full 
8. Pediatric services including: <ul style="list-style-type: none"> • appropriate immunizations • hereditary and metabolic screening at birth • newborn hearing screening test performed before the newborn infant is discharged from the hospital or birthing center • tuberculin tests, hematocrit, hemoglobin, and other appropriate blood tests and urinalysis • lead screening 	Covered in full
9. Female consultations, examinations, procedures, contraceptive devices, and medical services related to the use of all contraceptive methods*	Covered in full

* Prescription contraceptive devices are covered under the prescription drug benefit.

HP Independence

THE HARVARD PILGRIM INDEPENDENCE PLAN™ POS - MASSACHUSETTS

Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non Plan Providers and Plan Providers without a Referral Member Cost Sharing
Urgent Care Services (Continued)		
Please Note: Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefit. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory and Radiology Services."		
Vision Services		
– Routine eye examinations – limited to 1 exam every 24 months	Optometrist Copayment: \$20 per visit	Deductible, then 20% Coinsurance
	\$20	Ophthalmologist Copayment: – Tier 1 Specialist Copayment: \$30 per visit. – Tier 2 Specialist Copayment: \$60 per visit. – Tier 3 Specialist Copayment: \$90 per visit.
– Vision hardware (such as eyeglasses or contact lenses) only for limited conditions (please see your Benefit Handbook for details and limits on your coverage)	Deductible, then no charge	Deductible, then 20% Coinsurance
Voluntary Sterilization		
	Office visits: Tier 1 Specialist Copayment: \$30 per visit Tier 2 Specialist Copayment: \$60 per visit Tier 3 Specialist Copayment: \$90 per visit Surgical Day Care: \$250 Copayment per visit, then Deductible	Deductible, then 20% Coinsurance
Please Note: No In-Network Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: www.harvardpilgrim.org/GIC .		
Voluntary Termination of Pregnancy		
	Office visits: Tier 1 Specialist Copayment: \$30 per visit Tier 2 Specialist Copayment: \$60 per visit Tier 3 Specialist Copayment: \$90 per visit Surgical Day Care: \$250 Copayment per visit, then Deductible	Deductible, then 20% Coinsurance

HP Primary Choice

THE HARVARD PILGRIM PRIMARY CHOICE™ PLAN - MASSACHUSETTS

Benefit	Member Cost Sharing
Vision Services	
Routine eye examinations – limited to 1 exam every 24 months	Optometrist Copayment: \$20 per visit \$ 20 Ophthalmologist Copayment: – Tier 1 Specialist Copayment: \$30 per visit. – Tier 2 Specialist Copayment: \$60 per visit. – Tier 3 Specialist Copayment: \$90 per visit.
Voluntary Sterilization	
	Office visits: Tier 1 Specialist Copayment: \$30 per visit Tier 2 Specialist Copayment: \$60 per visit Tier 3 Specialist Copayment: \$90 per visit. Surgical Day Care: \$250 Copayment per visit, then Deductible
Please Note: No Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the "Preventive Services" notice at: www.harvardpilgrim.org/GIC .	
Voluntary Termination of Pregnancy	
	Office visits: Tier 1 Specialist Copayment: \$30 per visit Tier 2 Specialist Copayment: \$60 per visit Tier 3 Specialist Copayment: \$90 per visit. Surgical Day Care: \$250 Copayment per visit, then Deductible
Wigs and Scalp Hair Prostheses	
When needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury	No charge

Health New England

BENEFIT	Deductible Applies	Copay
Screening colonoscopy	No	\$0
Nutritional Counseling (<i>maximum of four visits per Policy Year</i>)	No	\$0
Other Outpatient Care		
PCP Office Visits	No	\$20/visit
Specialist Office Visits		
Specialists in Cardiology, Endocrinology, Gastroenterology, General Surgery, Obstetrics/Gynecology, Orthopedics, Otolaryngology, Pulmonology, and Rheumatology	No	*** Tier 1 (excellent): \$30/visit ** Tier 2 (good): \$60/visit * Tier 3 (standard): \$90/visit
Other Specialists	No	\$60/visit
Second Opinions		
Specialists in Cardiology, Endocrinology, Gastroenterology, General Surgery, Obstetrics/Gynecology, Orthopedics, Otolaryngology, Pulmonology, and Rheumatology	No	*** Tier 1 (excellent): \$30/visit ** Tier 2 (good): \$60/visit * Tier 3 (standard): \$90/visit
Other Specialists	No	\$60/visit
Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc™	No	\$20/consultation
Routine Eye Exams (<i>one each 24 months</i>)	No	\$20/visit
Hearing Tests in your PCP's office	No	\$20/visit
Diabetic-Related Items		
Endocrinology Specialist Office Visits	No	*** Tier 1 (excellent): \$30/visit ** Tier 2 (good): \$60/visit * Tier 3 (standard): \$90/visit
Laboratory/Radiological Services	Yes	\$0
Durable Medical Equipment (<i>diabetic-related; some items require Prior Approval</i>)	No	\$0
Individual Diabetic Education	No	\$20/visit
Group Diabetic Education	No	\$20/session
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder	No	\$0
Urgent Care Center or retail clinic visits	No	\$20/visit
Emergency Room Care (<i>Copay waived if admitted directly from ER</i>)	Yes	\$100/visit

\$20

NHP Prime

Applied Behavior Analysis (ABA) services beyond age three may be covered through Beacon (the organization that manages NHP's Behavioral Health program).

Emergency Services

Member cost: \$100 Copayment, then subject to Deductible (Copayment waived if admitted to hospital)

NHP covers Emergency services including ambulance services needed for transportation to the nearest facility. The Cost Sharing above includes all services you receive during the Emergency occurrence for the same hospital and date of service. If you need Emergency care, NHP will cover those services even when they are furnished by a Provider who is not an In-network Provider. You do not need a Referral from your PCP for Emergency Services. Simply go to the nearest Emergency facility or call 911 or the Emergency phone number.

An Emergency is defined as a medical condition, whether physical, behavioral, related to substance use disorder, or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).



Eye Care—Examinations (Vision Care)

Member cost: \$20 PCP Copayment, \$60 Copayment (Optometrist/Ophthalmologist)

NHP covers routine eye exams for Members once every 24 months. You may use any NHP Network ophthalmologist or optometrist for routine eye exams, and you do not need a Referral from your PCP. For all other non-routine eye care services (difficult vision, blurry vision, loss of vision), you must see your PCP who will arrange a Referral to an ophthalmologist (eye care Specialist).

There is no coverage for eyeglasses or contact lenses (except when Medically Necessary for certain eye conditions such as treatment of keratoconus and following cataract surgery), or low vision aids (except for visual magnifying aids used by legally blind Members with diabetes).

\$ 60

Family Planning Services

Member cost: \$0 Copayment

NHP covers consultations, examinations, procedures and other medical services provided on an outpatient basis and related to the use of all FDA approved contraceptive methods including but not limited to lab tests, birth control counseling, pregnancy testing, voluntary sterilization, IUDs, diaphragms, and Norplant. You can obtain services from your PCP, OB/GYN, Planned Parenthood, or any other NHP Provider who offers these services. All FDA-approved prescription contraceptive methods are covered.

Fitness Program Reimbursement

Reimbursement up to \$150 per individual or \$300 per family per calendar year and are provided for membership fees related to joining a qualified health club, gym, sports club or related physical fitness facility. To qualify for reimbursement, members must be enrolled in a qualified gym and NHP for at least four months and submit their reimbursement requests by March 31 of the following calendar year. Reimbursement amounts may not exceed the amount paid for the membership.

Gynecologic/Obstetric Care

Member cost: \$0 PCP Copayment, \$30/\$60/\$90 Specialty Copayment

NHP covers Medically Necessary gynecological and obstetrical services. You are not required to obtain a Referral or prior Authorization for Gynecological or Obstetric care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in NHP's Provider Network. However, the health care professional may be required to obtain prior Authorization for certain services and to follow procedures for making Referrals.

Habilitation Services

Member cost: \$35 Copayment per outpatient visit

Member cost for facility fee: \$275 Copayment,* then subject to Deductible per Inpatient admission

Member cost for professional fee: Subject to Deductible, then no copayment per Inpatient admission

NHP covers Medically Necessary Habilitation Services for qualified members with certain conditions. These are Health Care Services that help a person keep, learn, or improve skills and functioning for daily living.

Covered Services, Continued

Outpatient Care – continued

Short-term physical and occupational therapy services (may require prior approval from an Authorized Reviewer)

Physical and occupational therapy services, including cognitive rehabilitation or cognitive retraining, are covered for up to 30 visits for each type of therapy per calendar year for each type of therapy. These services are covered only when provided to restore function lost or impaired as the result of an accidental injury or sickness.

For these services to be covered, *Tufts Health Plan* must determine that the Member's condition is subject to significant improvement as a direct result of these therapies.

Notes: This benefit limit does not apply when these services are provided for the treatment of autism spectrum disorders. Massage therapy may be covered as a treatment modality only when administered as part of a physical therapy visit that is provided by a licensed physical therapist; and incompliance with *Tufts Health Plan's Medical Necessity* and (if applicable) prior authorization guidelines.

Urgent Care in an Urgent Care Center

Urgent Care refers to services provided when your health is not in serious danger, but you need immediate medical attention for an unforeseen illness or injury. To find an *Urgent Care Center* (a medical facility, clinic, or medical practitioner's office) in *Tufts Health Plan's* network, please visit tuftshealthplan.com and click on "Find a Doctor".

Note: Care that is rendered after the *Urgent* condition has been treated and stabilized and the Member is safe for transport is not considered *Urgent Care*.

Vision Care Services

Covered vision care services include:

- Routine eye exams (one exam in each 24-month period). Exams must be received from a Provider in the EyeMed Vision Care network in order to be covered. Please go to tuftshealthplan.com or contact Member Services at 800-870-9488 for more information.
- Eye examinations and necessary treatment of a medical condition

*\$20/copay in network
not subject to deductible*

EyeMed providers for exams/contacts

*Tufts
Navigator +
Tufts Spirit*

3: Find out what's covered

X Restrictions:

- Services received at a medical clinic, such as an urgent care center, are not covered as emergency room care.
- Non-emergency services performed at an emergency room are covered at the non-emergency benefit level. This means that, depending on what the service is, there may be a notification requirement, and you may also owe a copay and/or coinsurance.

☎ Notify UniCare – If you are admitted to the hospital from the emergency room, you or someone acting for you must notify UniCare Customer Service within 24 hours of, or the next business day after, being admitted.

Enteral therapy

Enteral therapy is prescribed nutrition that is administered through a tube that has been inserted into the stomach or intestines. Prescription and nonprescription enteral formulas are covered only when ordered by a physician for the medically necessary treatment of malabsorption disorders caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

	With CIC	Without CIC
Enteral therapy	<ul style="list-style-type: none"> ▪ From preferred vendors: Deductible, then 100% ▪ From non-preferred vendors: Deductible, then 80% 	<ul style="list-style-type: none"> ▪ From preferred vendors: Deductible, then 100% ▪ From non-preferred vendors: Deductible, then 80%

- ☎ Notify UniCare** – Contact UniCare Customer Service at least one business day before services start.
- ✓ Use preferred vendors** (page 27) – Enteral therapy from a UniCare preferred vendor is covered at 100% of the allowed amount. From non-preferred vendors, enteral therapy is covered at 80% and you owe 20% coinsurance. Your deductible applies to both types of vendors.
- 💻 To find UniCare preferred vendors**, go to the *Members* page of unicarestateplan.com and choose *Find a doctor*. You can also call UniCare Customer Service at 800-442-9300 for help.

X Eye care

Routine eye exams consisting of refraction and glaucoma testing are covered once every 24 months.

	With CIC	Without CIC
Routine eye exams Refraction / glaucoma testing	\$30/60/90 copay, then 100%; covered once every 24 months	\$30/60/90 copay, then 100%; covered once every 24 months
Eye care office visits When medically necessary	\$30/60/90 copay, then 100%	\$30/60/90 copay, then 80%

\$60
copay
Tiered Co-Pay

X Restrictions:

- Services received at a medical clinic, such as an urgent care center, are not covered as emergency room care.
- Non-emergency services performed at an emergency room are covered at the non-emergency benefit level. This means that, depending on what the service is, there may be a notification requirement, and you may also owe a copay and/or coinsurance.

Call Notify UniCare – If you are admitted to the hospital from the emergency room, you or someone acting for you must notify UniCare Customer Service within 24 hours of, or the next business day after, being admitted.

Enteral therapy

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All providers

Enteral therapy	<ul style="list-style-type: none">■ From preferred vendors: Deductible, then 100%■ From non-preferred vendors: Deductible, then 80%
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Call Notify UniCare – Contact UniCare Customer Service at least one business day before services start.

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Eye care

Routine eye exams consisting of refraction and glaucoma testing are covered once every 24 months.

All providers

Routine eye exams Refraction / glaucoma testing	\$30/60/90 copay, then 100%; covered once every 24 months
Eye care office visits When medically necessary	\$30/60/90 copay, then 100%

\$60
copay

Tiered
Co Pay

UniCare State Ind. Plan PLUS

Enteral therapy

3: Find out what's covered

PART 1:
Medical Plan

✖ Restrictions:

- Services received at a medical clinic, such as an urgent care center, are not covered as emergency room care.
- Non-emergency services performed at an emergency room are covered at the non-emergency benefit level. This means that, depending on what the service is, there may be a notification requirement, and you may also owe a copay and/or coinsurance.
- If you are admitted to a Massachusetts hospital from the emergency room, you'll owe the inpatient copay for that hospital's tier.

- ☎ Notify UniCare – If you are admitted to the hospital from the emergency room, you or someone acting for you must notify UniCare Customer Service within 24 hours of, or the next business day after, being admitted.

Enteral therapy

Enteral therapy is prescribed nutrition that is administered through a tube that has been inserted into the stomach or intestines. Prescription and nonprescription enteral formulas are covered only when ordered by a physician for the medically necessary treatment of malabsorption disorders caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

	Preferred vendors	Non-preferred vendors
Enteral therapy	PLUS deductible, then 100%	Non-PLUS deductible, then 80%

- ☎ Notify UniCare – Contact UniCare Customer Service at least one business day before services start.

- ✓ Use preferred vendors (page 28) – Enteral therapy from a UniCare preferred vendor is covered at 100% of the allowed amount. From non-preferred vendors, enteral therapy is covered at 80% and you owe 20% coinsurance. Your deductible applies to both types of vendors.

- ◻ To find UniCare preferred vendors, go to the *Members* page of unicarestateplan.com and choose *Find a doctor*. You can also call UniCare Customer Service at 800-442-9300 for help.

Eye care

Routine eye exams consisting of refraction and glaucoma testing are covered once every 24 months.

	PLUS providers	Non-PLUS providers
Routine eye exams Refraction / glaucoma testing	\$30/60/90 copay, then 100%; covered once every 24 months	\$30/60/90 copay, then 80%; covered once every 24 months
Eye care office visits When medically necessary	\$30/60/90 copay, then 100%	\$30/60/90 copay, then non-PLUS deductible, then 80%

\$60
copay

Tiered
Co Pay