

## UNISON KIDS HEALTH CARE BENEFITS

SERVICE*	COVERAGE*	LIMITATIONS
Allergy testing and treatment	covered	none
Ambulance service (non-emergency)	covered	covered when determined medically necessary
Ambulatory surgical center/short procedure unit services	covered	none
Blood and blood products	covered	Covers whole blood and blood components, such as plasma, platelets, and red, packed blood cells. The administration and processing of blood are covered services as part of a covered inpatient hospital stay. The storage of blood when done in preparation for a scheduled surgical procedure and transfusion supplies and equipment are covered when part of a covered inpatient hospital stay.
Certified registered nurse practitioner	covered	none
Dental services - emergency, preventive, and routine dental care including root canals, crowns and periodontics	covered	two examinations per year; orthodontia and cosmetic surgery excluded
Diabetic retinal eye examinations	covered	one examination per year
Durable medical equipment including at a minimum, the following requirements: <ul style="list-style-type: none"> <li>■ equipment that is primarily and usually used to serve a medical purpose;</li> <li>■ equipment that is generally not useful in the absence of an illness and injury;</li> <li>■ equipment that is appropriate for use in the home and school; and</li> <li>■ equipment that can withstand repeated use.</li> </ul>	covered	none

\* Depending on coverage level, copays may apply for certain services under the subsidized and at cost plans.

## HEALTH CARE BENEFITS

SERVICE*	COVERAGE*	LIMITATIONS
Eye care - emergency, preventive, and routine vision care including the cost of corrective lenses and frames	covered	one exam per year; two sets of lenses per year, maximum \$65 each; one frame per year, maximum \$60; <u>OR</u> one pair soft daily wear contacts for children 13 or older; annual diabetic retinal examinations are also covered.
Gynecological examinations	covered	one examination per year
Hearing aids	covered	one hearing aid per ear, per two years
Health programs: <ul style="list-style-type: none"> <li>■ Respiratory - Airways</li> <li>■ Pregnancy - Miracles</li> <li>■ Diabetes</li> </ul>	covered	call Member Services at 1.412.858.4320 in Pittsburgh or 1.800.414.9025 in other areas
Hearing care - emergency, preventive, and routine care, including the cost of examinations	covered	none
Home health care including professional services, intermittent skilled nursing care, physical therapy, speech therapy and other medical services and supplies when provided in conjunction with skilled services	covered	limited to 60 days per year
Hospitalization including services normally provided by the hospital	covered	up to 90 days per year, per eligible child (sum of inpatient Skilled Nursing Facility cannot exceed 90 days)
Laboratory, x-rays, diagnostic tests	covered	none
Maternity visits	covered	none
Medical foods benefits and diabetic supplies	covered	none
Mental health - partial hospitalization (usually treatments of 1/2 day or less)	covered	maximum of 30 days per year; lifetime benefit of 90 days

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# HEALTH CARE BENEFITS

SERVICE*	COVERAGE*	LIMITATIONS
Mental health services - inpatient	covered	90 days per year for eligible children; these days may be exchanged on a 2 to 1 basis for additional partial hospitalization services.
Mental health services - outpatient	covered	50 outpatient visits per year
Newborn care for a period of 31 days	covered	Covers routine nursery care, prematurity services, preventive health care services, as well as coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
Oral surgery services in connection with: A. accidental injury to the jaw or structures contiguous to the teeth, provided that care or treatment is sought within 24 hours of accident causing such injury; B. the correction of a non-dental physiological condition which has resulted in severe functional impairment; C. treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof, and floor of the mouth; and D. removal of partially or fully impacted wisdom teeth	covered	none
Organ transplants	covered	none
Outpatient services	covered	none
Pharmaceutical services <ul style="list-style-type: none"> <li>■ injectable medications</li> <li>■ prescribed drugs and biologicals</li> <li>■ over-the-counter drugs</li> </ul>	covered covered covered	none formulary applies; no copayments covered with prescription; limited to formulary items

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## HEALTH CARE BENEFITS

SERVICE*	COVERAGE*	LIMITATIONS
Physician care - inpatient	covered	none
Physician services	covered	none
Preventive services, including, but not limited to, well and sick child visits, immunizations, health education, tuberculosis testing, and developmental screening in accordance with routine schedule of well child visits.	covered	none
Rehabilitation - inpatient, including physical therapy, occupational therapy, inhalation therapy, and speech therapy.	covered	60 days per service type, per year, as long as there is significant improvement
Rehabilitation - outpatient therapy, including physical, speech, and occupational therapy.	covered	60 days per service type, per year, as long as there is significant improvement
Renal dialysis	covered	none
Skilled Nursing Facilities (SNF)	covered	up to 90 days per year, per eligible child (sum of inpatient SNF cannot exceed 90 days)
Substance abuse treatment - inpatient detoxification	covered	lifetime limit of four admissions and reimbursement for each admission is limited to seven days of treatment or an equivalent amount.
Substance abuse treatment - non-hospital residential services	covered	maximum of 90 days per year; lifetime benefit of 360 days
Substance abuse treatment - outpatient	covered	maximum of 90 outpatient sessions per year; lifetime limit of 360 sessions; these days may be exchanged on a 2 to 1 basis to secure up to 15 additional non-hospital residential treatment days

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