

# HEALTHCARE BENEFITS

## County Transportation Services

If you need a ride to your doctor's appointment, your county can help arrange for and provide transportation. Just call the telephone number of the county where you live. If you need assistance with this or your county is not listed on this page, just call the Unison Health Plan Member Services Department at 1.800.414.9025 or your local County Transportation Office.

### Voluntary

Blair	1.800.458.5552
Bradford	1.800.242.3484
Cambria	1.814.536.9031
Carbon	1.800.990.4287
Clarion	1.800.672.7116
Columbia	1.888.868.2320
Crawford	1.800.210.6226
Erie	1.800.323.5579
Forest	1.800.222.1706
Franklin	1.800.548.5600
Jefferson	1.814.938.3302
Lackawanna	1.717.383.3306
Luzerne	1.800.679.4135
Mercer	1.800.222.8797
Monroe	1.570.839.6282
Montour	1.570.271.0833
Pike	1.570.775.5550
Schuylkill	1.800.621.6325
Somerset	1.800.452.0148
Sullivan	1.800.242.3404
Susquehanna	1.800.323.2051
Warren	1.877.723.9456
Wyoming	1.800.679.4135

## Lehigh Capital

Adams	1.800.830.6473
Berks	1.610.921.2361
Cumberland	1.800.315.2546
Dauphin	1.717.232.6100
Lancaster	1.717.291.1243
Lebanon	1.717.273.8901
Lehigh	1.610.432.3200
Northampton	1.610.432.3200
Perry	1.877.800.7433
York	1.800.524.2766

## Health Choices Southwest

Allegheny	1.412.350.4484 or ...1.888.547.6287
Armstrong	1.724.548.3405 or ...1.800.468.7771
Beaver	1.724.728.5633 or ...1.800.262.0343
Butler	1.866.638.0598
Fayette	1.724.430.4600 or ...1.800.321.7433
Greene	1.724.627.6778 or ...1.724.852.2893
Indiana	1.724.463.3235 or ...1.888.526.6060
Lawrence	1.724.652.5588 or ...1.888.252.5104
Washington	1.724.223.8747 or ...1.800.331.5058
Westmoreland	1.724.832.2706 or ...1.800.242.2706

# HEALTHCARE BENEFITS

## Behavioral Health Information

Members who live in the following counties must continue to use your ACCESS card for mental health and substance abuse services. For more information on services, call one of the numbers listed below for your county. You may also call the Member Services Department at 1.800.414.9025.

	Mental Health Services	Substance Abuse Services
Blair	1.814.946.2279	1.814.946.2279
Bradford	1.800.588.1828	1.800.588.1828
Cambria	1.814.535.8531	1.814.536.5388
Carbon	1.610.377.0773	1.610.377.5177
Clarion	1.814.226.6252	1.814.226.6252
Columbia	1.570.287.6741	1.570.287.6741
Crawford	1.814.333.8793	1.814.724.4100
Erie	814.451.6800 or 1.814.451.6860 Crisis Hotline: 1.814.456.2014	1.814.451.6870
Forest	1.814.755.7995	1.814.755.7995
Franklin	1.717.264.2184	1.717.264.2184
Jefferson	1.800.734.5139	1.800.734.5139
Lackawanna	1.570.346.5741	1.570.278.1000
Luzerne	1.570.825.9441	1.570.826.8790
Mercer	1.724.981.2878	1.724.981.2878
Monroe	1.570.421.2901	1.570.421.1960
Montour	1.570.275.4692 or 1.570-275-6080	1.570.275.4692
Pike	1.570.296.6484	1.570.296.1054
Schuylkill	1.570.628.1180 or 1.570-874-0804	1.570.621.2890
Somerset	1.814.443.4891	1.814.443.3639
Sullivan	1.570.265.0100	1.570.265.0100
Susquehanna	1.570.278.3393	1.570.278.1000
Warren	1.814.726.2100	1.814.726.2100
Wyoming	1.570.836.3118	1.570.836.1101

If you live in Adams, Berks, or York County and you need behavioral health/substance abuse services, call one of the Community Care Behavioral Health (CCBH) numbers listed below:

Adams ..... 1.866.738.9849  
Berks ..... 1.866.292.7886  
York ..... 1.866.542.0299

If you live in Cumberland, Dauphin, Lancaster, Lebanon or Perry County, call Community Behavioral HealthCare Network of Pennsylvania (CBHNP) at 1.877.722.8646.

If you live in Lehigh or Northampton County call one of the Magellan Behavioral Health of PA numbers listed below:

Lehigh .....1.866.238.2312  
Northampton .....1.866.238.2312

If you live in Allegheny County and you need behavioral health/substance abuse services, call Community Care Behavioral Health Organization (CCBH) at 1.800.553.7499. You will be sent a separate card to use for these services.

If you live in Armstrong, Beaver, Butler, Fayette, Indiana, Lawrence, Washington or Westmoreland County, call one of the Value Behavioral Health (VBH) numbers listed below:

Armstrong .....1.877.688.5969  
Beaver .....1.877.688.5970  
Butler .....1.877.688.5971  
Fayette .....1.877.688.5972  
Indiana .....1.877.688.5974  
Lawrence .....1.877.688.5975  
Washington .....1.877.688.5976  
Westmoreland .....1.877.688.5977

If you live in Greene County and you need behavioral health/ substance abuse services, call 1.877.688.5973.

# HEALTHCARE BENEFITS

Benefits (subject to Unison policies and procedures)	Healthcare Benefit Package E-01 children under 21	Healthcare Benefit Package E-02 catagorically needy	Healthcare Benefit Package E-03 general assistance	Healthcare Benefit Package E-04 medically needy	Healthcare Benefit Package E-05 general assistance
<b>Abortion</b>	Covered* (under certain circumstances. Consent Form required.)	Covered* (under certain circumstances. Consent Form required.)	Covered* (under certain circumstances. Consent Form required.)	Covered* (under certain circumstances. Consent Form required.)	Covered* (under certain circumstances. Consent Form required.)
<b>Accupuncture</b>	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
<b>Allergy Testing</b>	Covered**	Covered**	Covered**	Covered**	Covered**
<b>Ambulance Emergency Medical Transportation</b>	Covered	Covered	Covered	Covered	Covered
<b>Ambulance Non-Emergency Medical Transportation</b>	Covered (age 18 & older. copay applies: \$1 per trip.)	Covered (copay applies: \$1 per trip.)	Covered (copay applies: \$1 per trip.)	Covered (copay applies: \$1 per trip.)	Covered (copay applies: \$1 per trip.)
<b>Behavioral Health (mental health &amp; substance abuse)</b>	Covered by county or behavioral health plan	Covered by county or behavioral health plan	Covered by county or behavioral health plan	Covered by county or behavioral health plan	Covered by county or behavioral health plan
<b>Blood &amp; Plasma Products</b>	Covered*	Covered*	Covered*	Covered*	Covered*
<b>Bone Mass Measurement (bone density)</b>	Covered**	Covered**	Covered**	Covered**	Covered**

\*Requires that your doctor call us at 1.800.366.7304 to get Prior Authorization.  
 \*\*Requires your primary care doctor to send in a referral for you to get this service.  
 Member May Self Refer - The member may choose a doctor from the Unison Health Plan Provider network.

Benefit limitations do not apply to pregnant members and those under the age of 21. Copayments do not apply for those members under 18, pregnant or in a nursing home.

# HEALTHCARE BENEFITS

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<b>Case Management</b>	Covered	Covered	Covered	Covered	Covered
<b>Chiropractor Services</b>	Covered*	Covered (maximum of 18 doctor visits combined per year, from July 1 – June 30)	Covered (maximum of 18 doctor visits combined per year, from July 1 – June 30)	Covered (maximum of 18 doctor visits combined per year, from July 1 – June 30)	Covered (maximum of 18 doctor visits combined per year, from July 1 – June 30)
<b>Colorectal/ Prostate Screening Exams</b>	Covered**	Covered**	Covered**	Covered**	Covered**
<b>Dental Services</b>	Covered (Includes full dental services.)	Covered (Includes full dental services.)	Covered (limited to cleanings, exams, x-rays every 6 months, simple extractions & fillings)	Covered (limited to cleanings, exams, x-rays every 6 months, simple extractions & fillings)	Covered (limited to cleanings, exams, x-rays every 6 months, simple extractions & fillings)
<b>Diabetic Education</b>	Covered	Covered (10 visits per year, from July 1 – June 30)	Covered (10 visits per year, from July 1 – June 30)	Covered (10 visits per year, from July 1 – June 30)	Covered (10 visits per year, from July 1 – June 30)
<b>Diabetic Supplies &amp; Equipment</b>	Covered (Some items may require Prior Authorization. Age 18 & older; copay applies: \$1 per item, up to \$3.)	Covered (Some items may require Prior Authorization. Copay applies: \$1 per item, up to \$3.)	Covered (Some items may require Prior Authorization. Copay applies: \$1 per item, up to \$6.)	Covered (Some items may require Prior Authorization. Copay applies: \$1 per item, up to \$3.)	Covered (Some items may require Prior Authorization. Copay applies: \$1 per item, up to \$6.)
<b>Dialysis</b>	Covered (member may self-refer.)	Covered (member may self-refer.)	Not Covered	Covered (member may self-refer.)	Not Covered

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# HEALTHCARE BENEFITS

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<b>Durable Medical Equipment</b>	Covered** (Prior Authorization required if greater than \$300. Age 18 & older; copay applies for purchase items: \$1 per item, up to \$3.)	Covered** (Prior Authorization required if greater than \$300. Copay applies for purchase items: \$1 per item, up to \$3.)	Not Covered (Unless you are also getting home health at the same time*; copay applies for purchase items: \$1 per item, up to \$6.)	Not Covered (Unless you are also getting home health at the same time*; copay applies for purchase items: \$1 per item, up to \$3.)	Not Covered (Unless you are also getting home health at the same time*; copay applies for purchase items: \$1 per item, up to \$6.)
<b>EPSDT (Early and Periodic Screening and Diagnostic Testing) Services/ Immunizations)</b>	Covered	Not Covered	Not Covered	Not Covered	Not Covered
<b>Emergency Room Care</b>	Covered	Covered	Covered	Covered	Covered
<b>Eye Tests, Routine</b>	Covered (Member may self-refer to participating provider.)	Covered (Member may self-refer to participating provider.)	Covered (Member may self-refer to participating provider.)	Covered (Member may self-refer to participating provider.)	Covered (Member may self-refer to participating provider.)
<b>Family Planning Services</b>	Covered (Member may self-refer to any family planning provider.)	Covered (Member may self-refer to any family planning provider.)	Covered (Member may self-refer to any family planning provider.)	Covered (Member may self-refer to any family planning provider.)	Covered (Member may self-refer to any family planning provider.)
<b>Hearing Aids &amp; Batteries</b>	Covered (age 18 and older; copay applies; \$1 per item, up to \$3.)	Not Covered	Not Covered	Not Covered	Not Covered

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# HEALTHCARE BENEFITS

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<b>Hearing Exams</b>	Covered**	Covered**	Covered**	Covered**	Covered**
<b>HIV/AIDS Testing</b>	Covered	Covered	Covered	Covered	Covered
<b>Home Health Care</b>	Covered*	Covered*	Covered* (30 visits per year from July 1 – June 30.)	Covered*	Covered* (30 visits per year from July 1 – June 30.)
<b>Hospice Care</b>	Covered*	Covered*	Covered*	Covered*	Covered*
<b>Immunizations</b>	Covered	Flu Vaccine Covered	Flu Vaccine Covered	Flu Vaccine Covered	Flu Vaccine Covered
<b>Infertility Testing &amp; Services</b>	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
<b>Inpatient Hospitalization (acute)</b>	Covered* (age 18 and older; copay applies: \$3 per day, up to \$21 maximum per stay.)	Covered* (Copay applies: \$3 per day, up to \$21 maximum per stay.)	Covered* (one stay per year, from July 1-June 30; copay applies: \$6 per day, up to \$42 maximum per stay.)	Covered* (Copay applies: \$3 per day, up to \$21 maximum per stay.)	Covered* (one stay per year, from July 1-June 30; copay applies: \$6 per day, up to \$42 maximum per stay.)

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# HEALTHCARE BENEFITS

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<b>Lab Tests &amp; X-rays</b>	Covered** (age 18 and older; copay applies to portable x-rays: \$1 per service.)	Covered** (copay applies to portable x-rays: \$1 per service.)	Covered** (copay applies to portable x-rays: \$1 per service.)	Covered** (copay applies to portable x-rays: \$1 per service.)	Covered** (copay applies to portable x-rays: \$1 per service.)
<b>Mammograms (screening)</b>	Covered (Member may self-refer.)	Covered (Member may self-refer.)	Covered (Member may self-refer.)	Covered (Member may self-refer.)	Covered (Member may self-refer.)
<b>Obstetrical/ Maternity Care</b>	Covered (Member may self-refer.)	Covered (Member may self-refer.)	Covered (Member may self-refer.)	Covered (Member may self-refer.)	Covered (Member may self-refer.)
<b>Organ Transplant Evaluation</b>	Covered*	Covered*	Covered*	Covered*	Covered*
<b>Organ Transplant</b>	Covered*	Covered*	Covered*	Covered*	Covered*
<b>Orthodontia</b>	Covered*	Not Covered	Not Covered	Not Covered	Not Covered
<b>Orthopedic Shoes</b>	Covered* (age 18 and older; copay applies: \$1 per item, up to \$3.)	Covered* (copay applies: \$1 per item, up to \$3.)	Not Covered (unless you are also getting home health at the same time. Copay applies for purchase items*: \$1 per item, up to \$6.)	Not Covered (unless you are also getting home health at the same time. Copay applies for purchase items*: \$1 per item, up to \$3.)	Not Covered (unless you are also getting home health at the same time. Copay applies for purchase items*: \$1 per item, up to \$6.)

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# HEALTHPLAN BENEFITS

Benefits (subject to Unison policies and procedures)	Healthcare Benefit Package E-01 children under 21	Healthcare Benefit Package E-02 catagorically needy	Healthcare Benefit Package E-03 general assistance	Healthcare Benefit Package E-04 medically needy	Healthcare Benefit Package E-05 general assistance
<b>Outpatient Surgery, performed at an Ambulatory Surgical Center or Short Procedure Unit</b>	Covered* (age 18 and older; Copay applies: \$1 per stay, up to \$3.)	Covered* (Copay applies: \$1 per stay, up to \$3.)	Covered* (Copay applies: \$1 per stay, up to \$6.)	Covered* (Copay applies: \$1 per stay, up to \$3.)	Covered* (Copay applies: \$1 per stay, up to \$6.)
<b>Pain Management Services</b>	Covered*	Covered* (maximum of 18 doctor visits combined per year, from July 1 – June 30.)	Covered* (maximum of 18 doctor visits combined per year, from July 1 – June 30.)	Covered* (maximum of 18 doctor visits combined per year, from July 1 – June 30.)	Covered* (maximum of 18 doctor visits combined per year, from July 1 – June 30.)
<b>Pap Smears and Pelvic Exams</b>	Covered (Member may self-refer.)	Covered (Member may self-refer.)	Covered (Member may self-refer.)	Covered (Member may self-refer.)	Covered (Member may self-refer.)
<b>Personal Care (in-home)/ Aide Services</b>	Covered (if related to EPSDT screening)	Not Covered	Not Covered	Not Covered	Not Covered
<b>Podiatry Care – Medically Necessary</b>	Covered**	Covered** (maximum of 18 doctor visits combined per year, from July 1-June 30)	Covered** (maximum of 18 doctor visits combined per year, from July 1-June 30)	Covered** (maximum of 18 doctor visits combined per year, from July 1-June 30)	Covered** (maximum of 18 doctor visits combined per year, from July 1-June 30)
<b>Prescription Drugs</b>	Covered (follow Drug formulary; age 18 & older; copay brand \$3; copay generic is \$1.)	Covered (follow Drug formulary; excludes medication for symptomatic relief of cough and cold; copay brand \$3; copay generic is \$1.)	Covered (6 prescriptions per month; Prilosec & Loratidine over the counter; Drug formulary; excludes medication for symptomatic relief of cough and cold; copay brand \$3; copay generic is \$1.)	Limited to birth control drugs	Limited to birth control drugs

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# HEALTHCARE BENEFITS

Benefits (subject to Unison policies and procedures)	Healthcare Benefit Package E-01 children under 21	Healthcare Benefit Package E-02 catagorically needy	Healthcare Benefit Package E-03 general assistance	Healthcare Benefit Package E-04 medically needy	Healthcare Benefit Package E-05 general assistance
<b>Primary Care Physician</b>	Covered	Covered	Covered	Covered	Covered
<b>Private Duty Nursing</b>	Covered*	Not Covered	Not Covered	Not Covered	Not Covered
<b>Prosthetics &amp; Orthotics</b>	Covered** (prior authorization required if greater than \$300. Age 18 & older; copay applies: \$1 per item, up to \$3.)	Covered** (prior authorization required if greater than \$300. Copay applies: \$1 per item, up to \$3.)	Not Covered (unless you are already getting home health at the same time.* Copay applies: \$1 per item, up to \$6.)	Not Covered (unless you are already getting home health at the same time.* Copay applies: \$1 per item, up to \$3.)	Not Covered (unless you are already getting home health at the same time.* Copay applies: \$1 per item, up to \$6.)
<b>Radiation/ Chemotherapy</b>	Covered (Member may self-refer.)	Covered (Member may self-refer.)	Covered (Member may self-refer.)	Covered (Member may self-refer.)	Covered (Member may self-refer.)
<b>Radiology Scans (MRI, MRA, PET)</b>	Covered*	Covered*	Covered*	Covered*	Covered*
<b>Rehabilitation (inpatient hospital)</b>	Covered* (age 18 and older; copay applies: \$3 per day, up to \$21 maximum per stay.)	Covered* (One stay per year, from July 1-June 30; copay applies: \$3 per day, up to \$21 maximum per stay.)	Covered* (One stay per year, from July 1-June 30; copay applies: \$6 per day, up to \$42 maximum per stay.)	Covered* (One stay per year, from July 1-June 30; copay applies: \$3 per day, up to \$21 maximum per stay.)	Covered* (One stay per year, from July 1-June 30; copay applies: \$6 per day, up to \$42 maximum per stay.)

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<b>Rehabilitation (outpatient occupational therapy/physical therapy/speech therapy)</b>	Covered* (age 18 and older; copay applies: \$1 per therapy visit, up to \$3.)	Covered* (Copay applies: \$1 per therapy visit, up to \$3.)	Covered* (Copay applies: \$1 per therapy visit, up to \$6.)	Covered* (Copay applies: \$1 per therapy visit, up to \$3.)	Covered* (Copay applies: \$1 per therapy visit, up to \$6.)
<b>Skilled Nursing Facility Care</b>	Covered* (for 30 continuous days)	Covered* (for 30 continuous days)	Covered* (for 30 continuous days)	Covered* (for 30 continuous days)	Covered* (for 30 continuous days)
<b>Sleep Apnea Studies</b>	Covered*	Covered*	Covered*	Covered*	Covered*
<b>Specialty Physician Services (except OB/GYN which member may self-refer)</b>	Covered**	Covered** (maximum of 18 doctor visits combined per year, from July 1-June 30.)	Covered** (maximum of 18 doctor visits combined per year, from July 1-June 30.)	Covered** (maximum of 18 doctor visits combined per year, from July 1-June 30.)	Covered** (maximum of 18 doctor visits combined per year, from July 1-June 30.)
<b>Tobacco Cessation Counseling</b>	Covered	Covered	Covered	Covered	Covered
<b>Tobacco Cessation Products</b>	Covered (age 18 and older; copay brand \$3; copay generic is \$1.)	Covered (copay brand \$3; copay generic is \$1.)	Covered (counted in 6 prescriptions per month limit; copay brand \$3; copay generic is \$1.)	Not Covered	Not Covered

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<b>Vision</b>	Covered (once per year: exam, standard eyeglass lenses or daily wear contact lenses; \$125.00 total allowance; in-plan frames covered in full. If vision provider does not carry in-plan frames a \$20 allowance will apply toward frames selected.)	Covered (once per year: exam, standard eyeglass lenses or daily wear contact lenses; \$125.00 total allowance; in-plan frames covered in full. If vision provider does not carry in-plan frames a \$20 allowance will apply toward frames selected.)	Covered (once per year: exam, standard eyeglass lenses or daily wear contact lenses; \$125.00 total allowance; in-plan frames covered in full. If vision provider does not carry in-plan frames a \$20 allowance will apply toward frames selected.)	Covered (once per year: exam, standard eyeglass lenses or daily wear contact lenses; \$125.00 total allowance; in-plan frames covered in full. If vision provider does not carry in-plan frames a \$20 allowance will apply toward frames selected.)	Covered (once per year: exam, standard eyeglass lenses or daily wear contact lenses; \$125.00 total allowance; in-plan frames covered in full. If vision provider does not carry in-plan frames a \$20 allowance will apply toward frames selected.)

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## Excluded Services

Limitations and most exclusion do not apply to members under the age of 21.

The following services are not covered for Unison Health Plan members:

- any health services that you don't need
- any cosmetic surgery UNLESS:  
the surgery is to improve the functioning of a malformed body member, to correct a visible disfigurement which would affect the person's ability to obtain or hold employment, or as post mastectomy breast reconstruction. (Services to treat the physical complications of all stages of mastectomy, including lymphedemas are covered.)
- organ transplants that are experimental
- infertility services
- services to lose weight
- services that you already have with Worker's compensation, Veteran's Administration (VA), or other programs or insurance
- transportation unless you need an ambulance for medical reasons (Unison can also assist you with transportation for the Well Child Program (EPSDT) visits.)
- more than 30 days in a nursing home - If you need to stay in a home for more than 30 days you will be taken off Unison and put on the Fee-For-Service (ACCESS) program
- for your eyeglasses, no UV coatings, or scratch guard (For children under 21, requests will be reviewed to see if they are needed.)
- no eyeglasses that are not prescription

## HEALTHCARE SERVICES

- no contacts that are (1) hard, (2) tinted, or (3) gas-permeable
- any services not authorized (O.K.'d) by Unison
- mental health and substance abuse services. Another company will provide these services. You will be told where to get these services when you enroll, or call the Member Services Department at 1.800.414.9025 for assistance.