Unity Health Plans Insurance Corporation

HMO BENEFIT PLAN

CERTIFICATE OF COVERAGE

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Unity Health Plans Insurance Corporation

HMO PLAN
Certificate of Coverage

Unity Health Plans Insurance Corporation ("Unity"), 840 Carolina Street, Sauk City, WI 53583, has entered into an agreement with your employer to provide you with a health insurance benefit plan. Unity has issued to your employer a Group Master Policy that outlines the duties and obligations of the parties. You and any dependents who are insured under the Group Master Policy are listed on an enrollment form that your employer has submitted to Unity.

This Certificate of Coverage is incorporated into and made part of the Group Master Policy. If the terms of this Certificate of Coverage differ from the terms of the Group Master Policy, the Group Master Policy will govern. This Certificate of Coverage replaces any previous Certificate that Unity may have issued to you. You may contact your employer's benefits manager if you wish to review the Group Master Policy.

This Certificate of Coverage explains the terms and conditions of your insurance coverage. Please read it carefully. If you have questions, contact your employer's benefit manager or Unity Customer Service.

Please Note: This is an HMO plan, and you are expected to obtain services from Unity's participating providers. If you obtain elective (non-emergency) services from a non-participating provider, the services must be prior authorized by Unity to be eligible for coverage. When you receive authorized services from a non-participating provider, benefits will be limited to the usual, customary and reasonable charge. This amount may be less than the billed charge. See the "Definitions" and "Obtaining Services" sections of this Certificate for more information.

With Unity's HMO plan, some benefits may be subject to a deductible, co-payment or co-insurance amount. For benefits subject to a deductible, you must satisfy the deductible before Unity will make payment for covered services. For benefits subject to co-payment or co-insurance, you are responsible for paying the co-payment or co-insurance amount listed in your Schedule of Benefits directly to the provider.

ARTICLE I: DEFINITIONS

The following terms are used in this **Certificate of Coverage**:

Activities of Daily Living (ADL)
The basic tasks of everyday life, such as eating, bathing, dressing, toileting, and transferring.

Allowed Amount
The maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **Provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing.)**

Ambulatory Surgery Center
A facility that provides treatment and care when an overnight stay is not necessary.

Ancillary Provider
Anesthesiologist, radiologist, pathologist, emergency room **Physician** and medical laboratory.

Appeal
A request for your health insurer or **Plan** to review a decision or a **Grievance** again.

Attending Physician
The **Physician** or other health care professional who is treating **You**.

Autism Spectrum Disorder
Includes any of the following:

1. Autism disorder.

2. Asperger's syndrome.

3. Pervasive developmental disorder not otherwise specified.

Balance Billing
When a **Provider** bills you for the difference between the **Provider's** charge and the **Allowed Amount.** For example, if the **Provider's** charge is $100 and the allowed amount is $70, the **Provider** may bill you for the remaining $30. A **Preferred Provider** may not balance bill you for covered services.

Behavioral Health (Mental Health) and Chemical Dependency (Substance Use Disorder) Services
The treatment of psychiatric **Illness** or alcohol and other drug abuse (AODA). This treatment is provided on an inpatient, outpatient, transitional and emergency care basis.

Benefit Period (or Benefit Year)
The 12-month period during which **Deductibles**, **Out-of-Pocket Expenses** and limitations accumulate.

Benefit Rider
An amendment to the **Group Master Policy** that adds or modifies **Plan Benefits** outlined in this **Certificate of Coverage**.

Case Management
The collaborative process that promotes quality health care in a cost-effective manner and which enhances the physical, psychological and social health of individuals. The goal of **Case Management** is to assist

patients and families in obtaining quality health care at an appropriate cost, in the appropriate setting, and to achieve positive outcomes through coordinated efforts with **Your** health care **Providers**. **Case Management** services are provided by a staff of health care professionals. **Unity** reserves the right to use these services to optimize the clinical outcome, the standards of care and the cost-effectiveness of care.

Certificate of Coverage (or Certificate)
This document, including any **Benefit Rider**, issued to **You** which sets forth the terms, conditions and limitations of **Your Health Plan**.

Change Form
The form that **You** must complete if **You** wish to add or delete **Dependents** or change the information on **Your Enrollment Form**. You may submit some changes electronically by logging on to **unityhealth.com**.

Charge
The fee charged by the **Provider** for the service or item provided.

Chemotherapy
Drugs and biologics that kill cancer cells directly, including antineoplastics, biologic response modifiers, hormone therapy, and monoclonal antibodies, and that are used to do any of the following:

1. Cure a specific cancer.
2. Control tumor growth when cure is not possible.
3. Shrink tumors before surgery or radiation therapy.
4. Destroy microscopic cancer cells that may be present after a tumor is removed by surgery to prevent a cancer recurrence.

Child
A **Subscriber's** natural blood-related child, stepchild, legally adopted child, child placed in the custody of the **Subscriber** for adoption, or a child for whom the **Subscriber** or the **Subscriber's** covered spouse has been appointed as legal guardian. Adopted children become **Dependents** when the court order for adoption is signed or when the **Child** is placed in the custody of the **Subscriber** who is to be the adoptive parent, whichever occurs first.

Claim
A demand for payment due in exchange for health care services provided. A **Claim** must have this minimum information: patient name and address, **Provider** name and address, description of services provided, date of service, reason for providing service and amount charged.

Co-insurance
Your share of the costs of a covered health care service, calculated as a percent of the **Allowed Amount** for the service. You pay **Co-insurance** *plus* any **Deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is $100 and you've met your **Deductible**, your **Co-insurance** payment of 20% would be $20. The **health insurance** or **plan** pays the rest of the **allowed amount**. **You** are responsible for paying **Co-insurance** directly to the **Provider**.

Complaint
Any expression of dissatisfaction to **Unity** by **You,** or a person acting on **Your** behalf, about **Unity** or **Unity's Participating Providers**.

Complications of Pregnancy

Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Confidential Matter
Personal information concerning the medical, personal or financial affairs that **Unity** may acquire about **You** in the course of administering **Plan Benefits**. **Confidential Matters** also include proprietary information and financial and other information relating to **Unity** and its **Providers**.

Confinement (or Confined)
1. The period of time between the admission to an inpatient or outpatient health care facility through the time of discharge. The health care facility may be a **Hospital**, an alcohol and other drug abuse treatment center, a **Skilled Nursing Facility** or a licensed **Ambulatory Surgical Center**.

2. The time spent receiving **Emergency Services** for **Illness** or **Injury** in a **Hospital**.

A **Hospital** swing bed **Confinement** is considered the same as **Confinement** in a **Skilled Nursing Facility**. In the event a **Member** is transferred from one facility to another for the continued treatment of the same or a related condition, it is considered one **Confinement**.

Congenital
A condition that exists at birth but is not hereditary.

Contract Year
The 12-month period following the **Effective Date** of the **Group Master Policy**.

Coordination of Benefits (COB)
A process that allows **Unity** to determine its respective payment responsibility. Through COB, **Unity** determines which insurance plan has primary payment responsibility when an individual is covered by more than one plan.

Co-payment
A fixed amount you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care. **You** are responsible for paying the **Co-payment** directly to the **Provider**.

Covered Expense
A **Charge** incurred for a **Covered Service**.

Covered Service
A **Medically Necessary** treatment, service or supply that has been specified as a benefit in this **Certificate of Coverage** or the **Schedule of Benefits.**

Custodial Care
The provision of room and board, nursing care, personal care or other care that is designed to assist an individual in the activities of daily living (e.g., eating, dressing, assistance in walking and preparing meals). **Custodial Care** is care and treatment that is generally received by an individual who has reached the maximum level of recovery in the opinion of the **Plan**. In the case of an institutionalized person, **Custodial Care** also includes room and board, nursing care or such other care provided to an individual for whom it cannot reasonably be expected, in the opinion of the **Attending Physician**, that medical or surgical treatment will enable that person to live outside an institution. **Custodial Care** includes rest care, respite care and home care provided by family members. Care may be considered **Custodial Care** as determined by the **Plan** even if: (a) the **Member** is under the care of a **Physician**; (b) the **Physician**

prescribes services to support and maintain the **Member's** condition; or (c) services and supplies are being provided by a registered nurse or licensed practical nurse.

Deductible
The amount you owe for health care services your **health insurance** or **plan** covers before your **health insurance** or **plan** begins to pay. For example, if your **Deductible** is $1000, your plan won't pay anything until you've met your $1000 **Deductible** for covered health care services subject to the **Deductible**. The **Deductible** may not apply to all services. Only **Charges** that qualify as **Covered Expenses** may be used to satisfy the **Deductible**. The amount of the **Deductible** is stated on the **Schedule of Benefits**.

Dependent
One or more of the following:

1. A **Subscriber's** lawful spouse.

2. A **Subscriber's Child** under the age of 26.

3. A **Subscriber's** adult **Child** who satisfies all of the following:

a. The **Child** is a full-time student; and

b. The **Child** was under 27 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. Armed Forces while the **Child** was attending, on a full-time basis, an institution of higher education, and applied to an institution of higher education as a full-time student within 12 months from the date the **Child** has fulfilled his or her active duty obligation.

4. A **Subscriber's** grandchild, if the parent of the grandchild is a **Dependent Child**. The **Dependent** grandchild is covered until the end of the month in which the **Dependent Child** turns age 18.

If a **Member** is the father of a **Child** born outside of marriage, the **Child** does not qualify as a **Dependent** unless and until there is a court order declaring paternity, or on the date the acknowledgment of paternity is filed with the Wisconsin Department of Health Services, or its equivalent if the birth was outside the State of Wisconsin. Once a **Child** becomes eligible for coverage, coverage will be effective according to the rules specified in the "Eligibility and Effective Date of Coverage" section of this **Certificate**.

A spouse and stepchildren will cease to be **Dependents** on the last day of the month in which a divorce decree is granted, and coverage may be terminated, subject to continuation and conversion rights. Other children cease to be **Dependents** at the end of the calendar month in which they reach age 26, except that:

1. **Full-time Students: Dependents** age 26 or older cease to be **Dependents** at the end of the calendar month in which they cease to be full-time students.

"Full-time student" means that the **Child** is in regular full-time attendance in one of the following types of schools:

a. An accredited post-secondary vocational, technical or adult education school.

b. An accredited college or university that provides a schedule of courses or classes and whose principal activity is the provision of an education.

Unity may require proof of attendance. Full-time student status is defined by the institution in which the student is enrolled. Coverage begins on the first day that the **Child** becomes a full-time student.

Student status includes any intervening vacation period if the **Child** continues to be a full-time student.

2. **Disabled Dependents:** If otherwise eligible, children who are or become incapable of self-support because of a physical or mental disability that is expected to be of a long-continued or indefinite duration may continue or resume their status as **Dependents**, regardless of age or student status, as long as they remain so disabled.

Written proof of incapacity and dependency must be provided to **Unity** in a form that is satisfactory to **Unity** within 31 days after the **Dependent** has attained the limiting age. Prior to granting continued coverage, **Unity**, in its sole discretion, may require that the **Dependent** be examined from time to time by a **Participating Provider** for the purpose of determining the existence of incapacity. Examinations may occur at reasonable intervals during the first two years after continuation under this provision is granted. Following that two-year period, such examinations may occur on an annual basis.

The **Subscriber** must notify **Unity** immediately in the event the incapacity or dependency ends.

3. A **Dependent** ceases to be a **Dependent** on the date he/she is:

a. Insured as a **Subscriber** in or through any other health plan; or

b. On active duty with the military service, including National Guard or reserves, other than for duty of less than 30 days.

Developmental or Learning Disability or Delay
A condition due to a **Congenital** abnormality, trauma, deprivation or disease that interrupts or delays the sequence and rate of normal growth, development and maturation, but excluding **Autism Spectrum Disorder**.

Disenrollment
Coverage under the **Plan** has ended or has been revoked by **Unity**.

Drug Formulary
A set of generic and brand name drugs that **Physicians** and pharmacists use to prescribe and fill prescriptions. **Unity's Drug Formulary** is designed to provide the desired medical results while controlling the cost of pharmaceuticals. **Unity's Drug Formulary** is reviewed and updated on a regular basis. Prescriptions covered by **Unity** must adhere to the **Drug Formulary**.

Dual Choice Enrollment Period
A period of time when **Members** who are currently enrolled in any of the employer's other group **Health Insurance Benefit Plans** will be allowed to enroll for coverage under a **Unity Health Plan**. The establishment of such an enrollment period must be by the mutual agreement of the employer and **Unity**.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care **Provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Effective Date
The date on which an **Employee** becomes enrolled in a **Unity Health Plan** and entitled to the benefits specified in the **Certificate of Coverage**.

Eligible Employee
An **Employee** who meets the requirements for eligibility as specified in the **Group Master Policy** and in the **Group Application**. An **Eligible Employee** is one who works 30 or more hours per week or, if less than 30 hours**,** at least as many hours as is specified by **Unity** in the **Group Application**. This term also includes a sole proprietor, a business owner, including the owner of a farm business, a partner of a partnership, a member of a limited liability company and an independent contractor, if the sole proprietor, business owner, partner, member or independent contractor is included as an **Employee** under the health plan of an employer, as defined by state and federal law. The term does not include an **Employee** who works on a temporary or substitute basis. An **Employee** who works on a temporary or substitute basis may be considered an **Eligible Employee** if his/her status is specifically identified for inclusion as part of the **Group Application**, and only if so approved by **Unity**.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

It is a condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a lack of immediate medical attention will likely result in any of the following:

1. Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn **Child**.

2. Serious impairment of the person's bodily functions.

3. Serious dysfunction of one or more of the person's body organs or parts.

Emergency Medical Transportation
Ground or Air ambulance services for an **Emergency Medical Condition.**

Emergency Room Care
Emergency Services you get in an emergency room.

Emergency Services
Evaluation of an **Emergency Medical Condition** and treatment to keep the condition from getting worse.

Employee
An individual whose employment or other status is the basis for his/her eligibility to enroll in this **Plan**.

Employer's Certification of Group Health Plan Coverage
A form that is provided to an individual following the termination of his/her coverage under the **Plan**. This form is evidence that the individual had coverage under the **Plan** and the duration of such coverage. **Unity** will issue the form directly to the individual following termination of coverage.

Enrollment Application Form (or Enrollment Form)
The form signed by an **Eligible Employee** to signify that he/she and any eligible **Dependents** wish to become **Members** of the **Plan**.

Essential Benefits
Essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. Such benefits shall include at least the following general categories and the items and services covered with the categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

e-Visit
An e-Visit is an electronic visit between a patient and **Provider** about a non-emergency health care concern. For certain symptoms, you can answer a series of questions. Your answers, along with your medical record information, give a **Provider** the information needed to treat you.

Excluded Services
Health care services that your **health insurance** or **plan** doesn't pay for or cover.

Exclusion
Any service or supply listed in the section entitled "Exclusions and Limitations." Those services or supplies listed as **Exclusions** are not covered by **Unity**, regardless of the **Medical Necessity**.

Expedited Grievance
A **Grievance** where the standard resolution process might lead to:

1. Serious jeopardy to the life or health of the **Member** or the inability of the **Member** to regain maximum function.

2. A situation where, in the opinion of the **Physician** with knowledge of the **Member's** medical condition, the **Member** would be subjected to severe pain that could not be adequately managed without the care or treatment that is the subject of the **Grievance**.

It is determined to be an **Expedited Grievance** by a **Physician** with knowledge of the **Member's** medical condition.

Expedited Review
A review process used when the standard review process would jeopardize **Your** life, health or ability to regain maximum function.

Expense
The **Charge** for a **Covered Service** or supply that **Unity** determines is the **Usual, Customary and Reasonable Charge**. An **Expense** is incurred on the date **You** receive the service or supply.

Experimental or Investigative Treatments and Services
Drugs, procedures, surgeries, equipment and devices that do not meet each of the criteria below, as determined by **Unity**:

1. The services must have FDA approval.

2. Scientific evidence must permit conclusions concerning the effect on health outcome.

3. The research and experimental stage of the development of the treatment or service must be completed.

This type of treatment or service is subject to review and determination by **Unity's Medical Director** in accordance with criteria developed by **Unity's** Technology Assessment Committee.

Explanation of Benefits (EOB)
An **EOB** is a statement sent by **Unity** to a **Member** explaining what medical treatments and/or services were paid on their behalf.

Extended Care Facility
A health care facility, or a distinct part of a health care facility, which has been accredited for that purpose by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Community Health Accreditation Program or **Medicare** as a **Skilled Nursing Facility**.

External Review (IRO)
A review of **Unity's** decision conducted by an **Independent Review Organization**.

Grievance
A complaint that you communicate to your **health insurer** or **plan**. It is any dissatisfaction with the provision of services or claims practices or the administration of a **Unity Health Plan** that is expressed in writing to **Unity** by or on behalf of a **Member**.

Group
The employer, union, trust or association to which **Unity** has issued a **Group Master Policy**. The **Group** is the basis for **Eligible Employees** and their **Dependents** to become entitled to coverage under the **Health Plan** described by this **Certificate of Coverage**.

Group Application
The form that is completed by a **Group** when it requests coverage from **Unity** for individuals in the **Group**.

Group Master Policy (or Group Master Agreement)
An agreement between **Unity** and a **Group** that entitles **Eligible Employees** of the employer to become **Subscribers** of the **Plan** according to the terms of such agreement.

Habilitative Services
Health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a **Child** who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium.**

Health Insurance Benefit Plan
Any health benefit plan that is any hospital or medical policy or certificate, as defined by secs. 632.745 and 632.746, Wis. Stats.

A **Health Insurance Benefit Plan** *does not* include any of the following:

1. Accident insurance or disability income insurance, or any combination of those two types.

2. Liability insurance or coverage issued as a supplement to liability insurance.

3. Worker's compensation or similar insurance.

4. Automobile medical payment insurance.

5. Credit-only insurance.

6. Coverage for on-site medical clinics.

7. If provided under a separate policy, certificate or contract of insurance, or, if the following is not an integral part of a policy, certificate or other contract of insurance:

a. Limited-scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of those benefits; or

c. Other similar, limited benefits as are specified in regulations issued by the Federal Department of Health and Human Services under sec. 2791 of P.L. 104-191.

8. Other similar coverage as specified in sec. 632.745(11)(b), Wis. Stats.

Health Plan (or Benefit Plan or Plan)
The overall program of health services insured and administered by **Unity**.

Health Questionnaire
The part of the **Enrollment Form** that requests information to develop the **Premium** rate.

Home Health Care
Health care services a person receives at home.

Home Health Care Services
Services to treat an **Illness** or **Injury** for which a **Member** was or could have been hospitalized or **Confined** in a **Skilled Nursing Facility**. This term shall have the same meaning as defined by the more liberal of Title XVIII of the Social Security Act or sec. 632.895 (1) (b), Wis. Stats.

Hospice Care
Palliative care services provided to a **Member** whose **Attending Physician** certifies that his or her life expectancy is 6 months or less. Care is available on an intermittent basis with on-call services available on a 24-hour basis. **Hospice Care** services ease pain and make the **Member** as comfortable as possible. **Hospice Care** must be provided through a licensed **Provider** approved by **Unity**.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospital
An acute care facility which:

1. Provides inpatient diagnostic and therapeutic services for surgical or medical diagnosis, treatment and care of injured and sick persons by or under the supervision of staff or duly licensed **Physicians**; and

2. Provides continuous nursing service by or under the supervision of registered professional nurses; and

3. Is not a federal hospital or, other than incidentally, a place for rest, a place for the aged or a nursing home; and

4. Operates as an acute care general or psychiatric hospital under applicable state or local laws.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

Identification Card
The card that **Unity** issues to **Members** to indicate that they are entitled to receive **Covered Services**.

Illness (or Sickness)
A condition or disease that causes the loss of, or affects, a normal body function, other than those conditions that result from an **Injury**.

Immediate Family
The spouse of the **Subscriber**; the **Dependents**, parents, grandparents, brothers and sisters of the **Subscriber** and their spouses.

Independent Review Organization (IRO)
An entity certified under State or Federal law to review **Unity's** decisions. Please refer to the Complaint and Grievance article for a description of the independent review process.

Infertility
The inability to establish pregnancy within one year by:

i. a **Member** and the **Member's** covered spouse, or by a **Member** and the **Member's** Domestic Partner who is covered in accordance with a Domestic Partner Rider attached to this certificate,
ii. who are both of reproductive age, and
iii. who both expect pregnancy to be accomplished by unprotected sex.

Injury
Harm or damage to **You** resulting from an accident, independent of all other causes.

In-network Co-insurance

The percent you pay of the **allowed amou**nt for covered health care services to **Providers** who contract with your **health insurance** or **plan. In-network Co-insurance** usually costs you less than **Out-of-network Co-insurance.**

In-network Co-payment
A fixed amount you pay for covered health care services to **Providers** who contract with your **health insurance** or **plan. In-network Co-payments** usually are less than **Out-of-network Co-payments**

Intensive-Level Services
Evidence-based behavioral therapy that is designed to help an individual with **Autism Spectrum Disorder** overcome the cognitive, social, and behavioral deficits associated with that disorder.

Late Applicant
An individual who:

1. Requests enrollment under the **Plan** more than 31 days after the initial date on which he/she becomes eligible; and

2. Who is not otherwise entitled to enroll during a **Special Enrollment Period**.

A **Late Applicant** who does not enroll during a **Special Enrollment Period** will be enrolled in this **Plan** with an **Effective Date** that is delayed 12 months following the date of his/her application.

Long-term Therapy
Any therapy that does not meet **Unity's** criteria for **Short-term Therapy**.

Maintenance and Supportive Care and/or Therapy
These terms are often used interchangeably to refer to therapies that seek to prevent disease in the absence of significant symptoms or to prevent deterioration of a condition once maximum therapeutic benefit has been achieved, even if symptoms are still present. The determination of what constitutes **Maintenance and Supportive Care and/or Therapy** is made by **Unity's Medical Director** after reviewing the **Member's** case history and/or treatment plan.

Medicaid
A program instituted pursuant to the federal "Grants to States for Medical Assistance Program." This program is governed by Title XIX of the United States Social Security Act, as it is now or hereafter amended.

Medical Director
A **Physician** appointed by **Unity** to serve as the **Plan's** final decision-maker for determining whether a service, device, treatment or supply is eligible for coverage under the **Plan**.

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Medically Necessary Services, Treatments or Supplies
A service, treatment, procedure, **Prescription Drug**, device or supply provided by a **Hospital**, **Physician** or other health care **Provider** that is required to identify or treat a **Member's Illness** or **Injury** and which is, as determined by the **Plan**:

1. Consistent with the symptoms or diagnosis and treatment of a **Member's Illness** or **Injury**; and

2. Appropriate under the standards of acceptable medical practice to treat that **Illness** or **Injury**; and

3. Not solely for the convenience of the **Member**, **Physician**, **Hospital** or other health care **Provider**; and

4. The most appropriate supply or level of service that can be safely provided to the **Member** and which accomplishes the desired end result in the most economical manner; and

5. Not primarily for cosmetic improvement of the **Member's** appearance, regardless of psychological benefit.

The **Member's Attending Physician** makes decisions regarding service and treatment. The **Plan**, through its **Medical Director**, using criteria developed by the University of Wisconsin Medical Foundation and other recognized sources, has the authority to determine whether a service, treatment, procedure, **Prescription Drug**, device or supply is **Medically Necessary** and eligible for coverage under the **Plan**.

Medicare
Title XVIII, Parts A, B, C and D of the United States Social Security Act, as it is now or hereafter amended.

Member
The **Subscriber** and any **Dependents** covered under a **Policy** issued by **Unity**.

Network
The facilities, **Providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

Non-Participating (or Out-of-Plan) Provider
A **Provider** who:

1. Does not have a signed contract to provide or arrange for the provision of **Plan Benefits** to **Unity Members**; or

2. Has a contract to provide or arrange for the provision of **Plan Benefits** to **Unity Members** but is not part of the **Provider Network** associated with the **Member's Primary Care Physician** selection; and

3. Is an **Ancillary Provider** providing services through a **Non-Participating Provider.**

Non-Preferred Provider
A Provider who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a **Non-Preferred Provider**. Check your policy to see if you can go to all **Providers** who have contracted with your **health insurance** or **plan**, or if your **health insurance** or **plan** has a "tiered" **network** and you must pay extra to see some **Providers**.

Open Enrollment Period
A period of time when all potential **Members** are allowed to enroll for coverage, whether or not they are currently enrolled in any of the employer's other health benefit plans. The establishment of an enrollment period must be by mutual agreement of the employer and **Unity**.

Out-of-network Co-insurance

The percent you pay of the **allowed amount** for covered health care services to **Providers** who do ***not*** contract with your **health insurance** or **plan. Out-of-network Co-insurance** usually costs you more than **In-network Co-insurance.**

Out-of-network Co-payment
A fixed amount you pay for covered health care services from **Providers** who do ***not*** contract with your **health insurance** or **plan. Out-of-network Co-payments** usually are more than **In-network Co-payments.**

Out-of-Pocket
A portion of a **Covered Expense** for which the **Member** is responsible for making payment. The **Expense** may be incurred because of applicable **Co-insurance, Co-payment** or **Deductible** amounts or because a **Charge** exceeds the **Usual, Customary and Reasonable Charge**.

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount.** This limit never includes your **premium, balance-billed** charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your **Co-payments, Deductibles, Co-insurance** payments, out-of-network payments or other expenses toward this limit.

Participating (or In-Plan) Provider
Any person or entity, public or private, that:

1. Has entered into a contract to provide or arrange for the provision of **Plan Benefits** to **Unity Members**; or

2. Provides services through and in accordance with the **Provider Network** associated with the **Member's Primary Care Physician** selection; and

3. Is an **Ancillary Provider** providing services through a **Participating Provider.**

Physician
A person holding an active, unrestricted license to practice medicine and/or surgery under Wisconsin law or under the laws of the state in which he or she practices.

Physician Services
Health care services a licensed medical physician (M.D. — Medical Doctor or D.O. — Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Plan Benefits
Medical, **Hospital**, **Behavioral Health and Chemical Dependency**, Chiropractic, **Home Health Care**, **Skilled Nursing Facility**, Emergency Care and other specified **Covered Services** as defined in the **Group Master Policy**, **Certificate of Coverage**, **Schedule of Benefits** and **Benefit Riders** to which a **Member** is entitled by membership in the **Plan**.

Policy
An agreement between **Unity** and an employer wherein **Unity** agrees to provide a **Group Health Plan** to the employer's **Eligible Employees** and their eligible **Dependents**. The **Policy** sets forth all of the obligations, rights and responsibilities of the parties. The **Policy** includes all of the following:

1. The **Group Master Policy**;

2. The **Certificate of Coverage**;

3. The **Schedule of Benefits**;

4. Any **Benefit Riders**;

5. The **Group Application**;

6. The **Enrollment Forms**; and

7. The **Provider Network Directory**.

Post-Intensive-Level Services
Therapy for an individual with **Autism Spectrum Disorder** that occurs after the completion of treatment with **Intensive-Level Services** and that is designed to sustain and maximize gains made during treatment with **Intensive-Level Services** or, for an individual who has not and will not receive **Intensive-Level Services**, therapy that will improve the individual's condition.

Preauthorization
A decision by your health insurer or **plan** that a health care service, treatment plan, **Prescription Drug** or **Durable Medical Equipment (DME)** is **medically necessary.** Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or **plan** may require **Preauthorization** for certain services before you receive them, except in an emergency. **Preauthorization** isn't a promise your health insurance or **Plan** will cover the cost.

Preferred Provider
A **Provider** who has a contract with your health insurer or **Plan** to provide services to you at a discount. Check your policy to see if you can see all **Preferred Providers** or if your **health insurance** or **plan** has a "tiered" network and you must pay extra to see some **Providers**. Your health insurance or plan may have **Preferred Providers** who are also **"Participating" Providers**. **Participating Providers** also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your **health insurance** or **Plan.** You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or **plan** that helps pay for **Prescription Drugs** and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Preventive Health Services
1. Evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;

2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

4. With respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.

5. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current.

Primary Care Physician (also PCP)
A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

The **PCP** provides the full range of primary health care services of the type ordinarily provided by:

1. General Practitioners;

2. Internists;

3. Family Practitioners;

4. Pediatricians;

5. OB/GYN's; and

6. Geriatricians.

At the time of enrollment, each **Member** must select a **Primary Care Physician** to provide and coordinate his/her medical care. **PCPs** are listed in **Unity's Provider Network Directory**.

Primary Care Provider
A physician (M.D. — Medical Doctor or D.O. — Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Prior Authorization
The process by which **Unity** gives prior written approval for coverage of specific **Covered Services**, treatment, **Durable Medical Equipment (DME), Prescription Drugs** and supplies. The purpose of **Prior Authorization** is to determine and authorize the following:

1. The specific type and extent of care, **DME**, **Prescription Drug** or supply that is necessary;

2. The number of visits, or the period of time, during which care will be provided;

3. The name of the **Provider** to whom the **Member** is being referred; and

4. Whether the **Member** should receive coverage for the services of a **Non-Participating Provider** because needed services are not available from **Participating Providers**.

Prior Authorization does not guarantee that services will be fully covered. Coverage is determined by the terms and conditions of the **Policy**. Services and items requiring **Prior Authorization** are listed on **Unity's** website at **unityhealth.com**. Contact **Unity** Customer Service for details on the **Prior Authorization** process.

Provider
A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Provider Network
Physicians and other **Providers** who have contracted with or on behalf of **Unity** to provide **Plan Benefits** to **Members**. Visit Find A Doctor at **unityhealth.com** or contact **Unity** Customer Service for assistance in locating **Providers** who are in the **Provider Network**.

Provider Network Directory
A listing of **Physicians** and other **Providers** who are available to provide health care services to **Members**. Visit Find A Doctor at **unityhealth.com** or contact **Unity** Customer Service for assistance in locating **Providers** who are in the **Provider Network**.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions. **Reconstructive Surgery** includes breast reconstruction following a covered mastectomy.

Referrals and Standing Referrals
A written form that authorizes **You** to receive coverage for certain health care services. The purpose is to determine and authorize the following:

1. The specific type and extent of care that is necessary; and

2. The number of visits or the period of time during which care will be provided; and

3. The **Provider** to whom the **Member** is being referred.

Requests for **Referrals** must be submitted to **Unity** for consideration and review before the requested services are obtained. Such services will be covered only if the **Referral** request is authorized by **Unity** before services are obtained.

No referral is necessary for obstetrical or gynecological care provided by **In-Network Providers** who specialize in obstetrics or gynecology.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Rider
An amendment to the **Health Plan** that adds benefits to the **Covered Services** outlined in the **Policy**.

Schedule of Benefits
A summary of the **Covered Services** provided by the **Policy**. The **Schedule of Benefits** lists the **Co-payment**, **Co-insurance** and **Deductible** amounts that may apply to the **Covered Services** under the **Policy**.

Service Area
The counties within which **Unity** is authorized by the Wisconsin Office of the Commissioner of Insurance to do business and where **Unity** has determined that there are enough **Participating Providers** to serve its **Members**.

Short-term Therapy
Physical, speech, occupational, manipulative or respiratory therapy that is likely to significantly improve a **Member's** condition within 60 days from the date the therapy begins, as determined by **Unity**.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home. **Skilled Care** must be **Medically Necessary** as determined by **Unity**. Services to support activities of daily living (ADL), even if provided by a licensed, registered or practical nurse, are not **Skilled Care**.

Skilled Nursing Facility
A facility that is licensed by the State of Wisconsin, or another state, that maintains and provides all of the following:

1. Permanent and full-time bed care facilities for resident patients.

2. **Physician** services available at all times.

3. A registered nurse or **Physician** in charge and on full-time duty and one or more registered nurses or licensed vocational or practical nurses on full-time duty.

4. A daily record for each patient.

5. Continuous **Skilled Nursing Care** for patients during convalescence from **Illness** or **Injury**.

A **Skilled Nursing Facility** is not, except by coincidence, any of the following:

1. A rest home.

2. A home for care of the aged.

3. A facility engaged in the care and treatment of alcoholics, drug addicts or persons with psychiatric disorders.

Skilled Nursing Facility Services
The health care services provided by a **Skilled Nursing Facility** or **Extended Care Facility** as part of its licensed operations. These services must be designated as **Covered Services** by **Unity**.

Small Employer
An employer that:

1. Employs an average of 2-50 **Employees** on business days during the preceding calendar year; or

2. Is reasonably expected to employ 2-50 **Employees** on business days during the current calendar year if the employer was not in existence during the preceding calendar year, and that employs at least 2 **Employees** on the first day of the **Plan** year; or

3. Meets the most current definition of "**Small Employer**" as defined by state or federal law.

Sound Natural Tooth
A tooth that would not have required restoration in the absence of trauma or **Injury**, or a tooth with restoration limited to composite or amalgam filling, but not a tooth with crowns or a tooth that has had root canal therapy.

Special Enrollment Period
A 31-day period of time during which a **Late Applicant** is allowed to enroll in the **Health Plan** without having to serve a **Waiting Period**. The **Special Enrollment Period** begins on the date the **Late Applicant**:

1. Loses coverage under a **Health Insurance Benefit Plan** or other health plan; or

2. Gains a **Dependent** through marriage, birth, legal guardianship, adoption or placement for adoption.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **Provider** who has more training in a specific area of health care.

Subscriber
An **Eligible Employee** who is enrolled in a **Health Plan** issued by **Unity** to his/her employer under a **Group Master Policy**.

Third Party Examinations, Services and/or Supplies
Services and/or supplies that are provided primarily at the request of, for the protection of, or to meet the requirements of, a party other than the **Member**. These services and supplies are not considered to be **Covered Services** unless:

1. The service and/or supply is otherwise **Medically Necessary**; or

2. The service and/or supply is mandated by state or federal law.

Total Disability (or Totally Disabled)
For a **Subscriber**, this term means that, because of an **Illness** or **Injury**, he/she is at all times unable to perform the duties of the job or occupation for which he/she is reasonably qualified for wage or profit. **Total Disability** also means that the **Subscriber** cannot engage in any job or occupation for wage or profit.

For a **Dependent**, **Total Disability** means a disability that prevents a person from engaging in substantially all of the usual and customary activities of a person in good health and of the same age and gender.

Unity's Medical Director makes the determination as to whether or not a **Member** is **Totally Disabled**.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what **Providers** in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount.**

Unity
Unity Health Plans Insurance Corporation and the overall program of health benefits that are insured and administered pursuant to the **Policy**. **Unity** is a health maintenance organization that operates pursuant to Chapters 609 and 611, Wis. Stats., or any succeeding provisions of Wisconsin law.

unityhealth.com
A comprehensive website resource to guide **You** through Your health plan benefits and educate You about Unity's health and wellness programs. The internet domain name for this site is: **https://unityhealth.com**.

Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **Emergency Room Care.**

Urgent Care Services
Those services that are warranted by **Illness**, **Injury** or symptoms where delay in the receipt of the care or treatment would jeopardize the **Member's** health or result in a disability. These services include treatment received from health care professionals and health care facilities.

Usual, Customary and Reasonable Charge
The reasonable dollar amount **Charge** for the services and supplies provided by a health care **Provider**. The **Usual, Customary and Reasonable Charge** is not more than the following:

1. The **Usual Charge**, which is the fee charged by the **Provider** for a service or item to the majority of his/her patients;

2. The **Customary Charge**, which is the fee that falls within a range of the **Usual Charges** of most **Providers** in a geographic area that will generate a statistically credible claims distribution for the same or similar service;

3. The **Reasonable Charge**, as determined by **Unity**, which considers the complexity of a given treatment required for a particular case; or

4. A **Charge** negotiated by **Unity** with a **Participating Provider**. If a **Provider** is not a **Participating Provider**, **Unity** will pay based on the **Usual, Customary and Reasonable** amount as determined by **Unity**.

You may request the amount that **Unity** has determined to be the **Usual, Customary and Reasonable Charge** by completing a Determination of Benefits Worksheet available at **unityhealth.com** or by contacting **Unity** Customer Service. **You** must furnish the **Provider's** name, address, the actual **Charge**, the appropriate procedure code and the date of service.

Waiting Period
The 12-month period of time, or that period up through an **Open Enrollment Period**, if available, whichever comes first, for which a **Late Applicant** will not be covered under this **Health Plan**. A **Late Applicant** must remain continuously employed with the employer during the 12-month period or up to an **Open Enrollment Period**, if available, whichever comes first. A **Dependent** of an **Eligible Employee** must remain a **Dependent** of that **Eligible Employee** during the 12-month period, or up to an **Open**

Enrollment Period, if available, whichever comes first. The **Waiting Period** must be served with the same employer.

We/Us/Our
Unity Health Plans Insurance Corporation or **Unity**.

You/Your
A **Member** enrolled in a **Unity Health Plan**.

ARTICLE II: OBTAINING SERVICES

As a **Member** of **Unity's *HMO Benefit Plan***, **You** are entitled to benefits that are **Covered Services** whenever **You** obtain such health care services through **Your Primary Care Physician** or with an approved **Referral** to a **Participating Provider** in accordance with the guidelines set forth in this section of **Your Certificate of Coverage**. Preventive care, as well as treatment for **Illness** or **Injury**, is a **Covered Service** as shown in the **Certificate of Coverage**. **You** should obtain such services through **Your** chosen **Primary Care Physician**. Benefits that are **Covered** Services are described in the **Schedule of Benefits** and this **Certificate**.

If **Your Plan** includes a **Deductible**, then the **Deductible** must be paid in full before **Unity** will make any payment for **Covered Services**. Once the **Deductible** has been satisfied, any **Co-payments** or **Co-insurance** required may apply toward satisfaction of the **Annual Out-of-Pocket Expense** limit. For specific information, refer to the **Schedule of Benefits**.

A. Prior Authorization

Prior Authorization may be required in order for **You** to receive coverage for certain **Covered Services.** A request for **Prior Authorization** must be made before **You** obtain the services. Also, if **You** or **Your Primary Care Physician** believe that **You** need to obtain health care services from a **Non-Participating Provider**, **You** must obtain **Prior Authorization** from **Unity** before **You** obtain the services. A list of services requiring **Prior Authorization** is available at **unityhealth.com**. **You** may contact **Unity** Customer Service or consult **Your Participating Primary Care Physician** to obtain information about **Prior Authorization**.

Prior Authorization does *not* guarantee that benefits will be fully covered. Coverage is determined by the terms and conditions of **Your Health Plan**.

*If **You** fail to provide the required notice, **Your** benefit may be reduced by $1,000. This penalty will not apply toward **Your Deductible** or **Out-of-Pocket** limit.*

*If **You** fail to provide the required notice of a **Medically Necessary** inpatient admission to a **Non-Participating Hospital** within 3 business days, **Your** in-patient **Hospital** benefits will be reduced by $1,000.* This amount will not apply toward **Your Deductible** or **Out-of-Pocket** limit.

These penalties will not reduce state-mandated benefits.

B. Primary Care Physician

At the time **You** enroll in the **Plan**, **You** and each of **Your** covered **Dependents** must select a **Participating Primary Care Physician (PCP)**. Each **Member** may select a different **PCP**. **Your PCP** will provide primary health care services and will coordinate the care **You** receive from other health care professionals.

You may change **Your PCP** by logging on to **unityhealth.com** or by contacting **Unity** Customer Service. The change will be effective no later than the first day of the following month. The change will be made as long as the new **Physician** is accepting additional patients.

Unity reserves the right to modify the list of **Plan Providers** at any time.

C. Referrals and Standing Referrals

Your Primary Care Physician is responsible for providing and coordinating **Your** health care. Depending upon the rules of the **Provider Network** to which **Your Primary Care Physician** belongs, **You** may need to obtain a **Referral** or **Standing Referral** before **You** obtain specialty care.

Please ask **Your Primary Care Physician** if a **Referral** is required, or contact **Unity** Customer Service for information.

A **Referral** determines and authorizes:

1. The type and extent of care that is necessary; and

2. The number of visits or period of time during which care will be provided; and

3. The **Provider** to whom the **Member** is being referred.

D. Behavioral Health Services

For assistance in accessing **Behavioral Health Services**, contact Behavioral Health Care Management at (800) 683-2300.

E. Non-Emergency Care

Elective (**Non-Emergency**) health care services are **Covered Services** only if **You** receive the services from **Your Primary Care Physician** or other **Participating Provider**. Services must be obtained in accordance with any applicable **Referral** and **Prior Authorization** requirements. Coverage is subject to all of the terms, conditions, limitations and **Exclusions** stated in the **Certificate of Coverage** and **Schedule of Benefits**.

F. Emergency Care

You do not need **Prior Authorization** or a **Referral** to access **Emergency Services**. If **You** experience an **Emergency Medical Condition**, seek immediate care from the nearest health care **Provider**. Then contact **Your Primary Care Physician** to arrange for follow-up care from a **Participating Provider**. Follow-up care will not be covered as **Emergency Services**.

G. Urgent Care

If you need **Urgent Care Services**, call **Your Primary Care Physician** for instructions if possible. Otherwise, seek treatment at the nearest urgent care facility.

If **You** receive **Urgent Care Services** from a **Non-Participating Provider**, **You** must notify **Unity** within 3 business days of receiving the care, or as soon thereafter as is medically feasible, whichever is later. Contact **Unity** Customer Service to provide this notice.

*If **You** fail to provide the required notice, **Your** benefit may be reduced by 50% of the **Covered Expense** or $250, whichever is less.* This penalty will not apply toward satisfaction of **Your Deductible** or **Out-of-Pocket** limit.

H. Emergency Inpatient Admissions

You, or someone acting on **Your** behalf, are required to notify **Unity** of all **Emergency Inpatient Admissions** to a **Non-Participating Hospital**. **You** must notify **Unity** no later than 3 business days following the day of admission, or as soon thereafter as is medically feasible, whichever is later. Contact **Unity** Customer Service to provide this notice. **Participating Providers** will provide this notice for you.

I. Special Provisions Relating to Full-Time Students

1. Behavioral Health and Chemical Dependency Benefits

A full-time student attending a school (other than a primary or secondary school) located in the State of Wisconsin but outside **Unity's Service Area** will be covered for a clinical assessment of nervous or mental disorders, or alcoholism and other drug abuse problems. If it is recommended as a result of that assessment, the student will be covered for up to 5 visits to an outpatient treatment facility or to another health care **Provider**. That **Provider** must be located in reasonably close proximity to the school in which the student is enrolled. After the student has completed 5 such visits, **Unity** will review the student's condition and determine whether it is appropriate for the student to continue treatment with that same **Provider**.

Unity will not provide coverage for this treatment if it is determined that the nature of the treatment would prevent the student from attending school on a regular basis. **Unity** reserves the right to make this determination.

2. Dependents Attending School Outside Unity's Service Area

Unity will provide limited coverage for elective (**Non-Emergency**) services for **Dependents** who are full-time students at an accredited school located outside **Unity's Service Area**. This coverage is subject to the Deductible shown in the Schedule of Benefits. Coverage is limited to 50% of the **Usual, Customary and Reasonable Charge** as determined by **Unity**. All services must be **Prior Authorized** by **Unity's** Medical Management Department to be eligible for coverage. Call (888) 829-5687 to authorize services. Medical Management will not authorize a service after the service has been obtained.

The school must be:

a. An accredited, post-secondary vocational, technical or adult education school.

b. An accredited college or university that provides a schedule of courses or classes and whose principal activity is the provision of an education.

3. Students on Medical Leave

If a **Dependent** over age 26 who is a full-time student must take a **Medically Necessary** leave of absence from school due to **Illness** or **Injury**, **Unity** will continue to provide coverage for the **Dependent** if he or she, or an individual acting on his or her behalf, submits documentation and certification of **Medical Necessity** for the leave of absence from the **Dependent's Attending Physician**. The date on which the **Dependent** ceases to be a full-time student due to the **Medically Necessary** leave of absence is the date on which continuation of coverage under this provision begins.

Unity will continue to provide coverage to the **Dependent** until any one of the following events occurs:

a. The **Dependent**, or an individual acting on his or her behalf, advises **Unity** that the **Dependent** does not intend to return to school full-time.

b. The **Dependent** becomes employed full-time.

c. The **Dependent** obtains other health insurance coverage.

d. The **Dependent** marries.

e. Coverage of the person through whom the **Dependent** has coverage under this **Plan** is discontinued or not renewed.

f. One year has elapsed since the **Dependent's** coverage continuation began and the **Dependent** has not returned to school on a full-time basis.

Full-time student status is defined by the school in which the student is enrolled. **Unity** may require proof of attendance. Coverage begins on the day the student becomes a full-time student and ends on the day he/she is no longer a full-time student, or the last day of the month in which he/she attains the limiting age, whichever occurs sooner.

ARTICLE III: COVERED SERVICES

Members are entitled to **Covered Services** subject to the terms and conditions of the **Health Plan**, as set forth in this **Certificate of Coverage**, the **Schedule of Benefits** and any **Benefit Riders** attached to this **Certificate**.

Services and supplies are covered only when they are **Medically Necessary**. Services and supplies are **Covered Services** only if they are: (a) provided by or at the direction of a **Participating Provider**; and (b) provided in accordance with the guidelines set forth in the "Obtaining Services" section of this **Certificate**. **Plan Benefits** are described in this **Certificate of Coverage**, the **Schedule of Benefits** and any applicable **Benefit Riders**.

NOTE: *If **Unity** has **Prior Authorized** benefits to be received from a **Non-Participating Provider,** the benefits to be paid are limited to the **Usual, Customary and Reasonable Charge**. This amount may be less than the billed **Charge**.*

Some or all **Covered Services** may be subject to **Co-payment, Co-insurance** and **Deductible** amounts. For specific information, refer to the **Schedule of Benefits**.

IMPORTANT NOTICE:

You *may contact **Unity** Customer Service **before** receiving services from a **Non-Participating Provider** to determine if a **Provider's Charge** will be within **Unity's Usual, Customary and Reasonable Charge** range. A Benefits Determination Worksheet may be completed at **unityhealth.com.** If **You** call, **You** must provide **Unity** with the following information:*

1. *The **Provider's** estimated **Charge**;*
2. *The CPT code of the service(s) to be obtained;*
3. *The **Provider's** name and zip code; and*
4. *The anticipated date of service.*

A. <u>Professional and Related Services</u>

Professional and related services include medical, surgical and other services listed in this **Certificate of Coverage**. Benefits are subject to: (a) any **Deductible, Co-payment, Co-insurance** and other limitations shown on the **Schedule of Benefits**; and (b) all other terms and conditions outlined in this **Certificate**. Specific services require **Prior Authorization**. Failure to obtain **Prior Authorization** when necessary will result in a reduction of the benefit paid.

1. <u>Ambulance Services</u>

Covers established ambulance service or comparable mode of **Emergency Medical Transportation** to the nearest **Hospital** when it is clear that **Emergency Services** are needed and medical care is required during transport. Transportation between **Hospitals** is covered when it is **Prior Authorized** by **Unity**.

2. <u>Anesthesia Services</u>

a. <u>General Anesthesia</u>

Covered when connected with the medical and surgical benefits described in this **Certificate**.

b. **Dental Anesthesia**

Anesthesia services for dental care are covered under certain circumstances subject to **Prior Authorization** requirements. These services are covered if any of the following applies:

i. The **Member** has a chronic disability that meets all of the conditions under sec. 230.04(9r)(a)2., Wis. Stats.

ii. The **Member** has a medical condition that requires hospitalization or general anesthesia for dental care.

3. **Autism Spectrum Disorder**

Treatment for the condition of **Autism Spectrum Disorder**:

a. Services to a **Member** with a primary verified diagnosis of **Autism Spectrum Disorder** made by a **Provider** skilled in testing and in the use of empirically validated tools specific for **Autism Spectrum Disorder**. **Unity** may require a second opinion from a **Provider** that is mutually agreeable to the **Member** or the **Member's** parent and **Unity**. **Unity** may require that the assessment include both a standardized parent interview as well as a direct structured observation of social and communicative behavior and play.

b. The treatment is prescribed by a physician and provided by any of the following who are qualified to provide **Intensive-Level Services** or **Post-Intensive-Level Services**:

i. A psychiatrist.

ii. A person who practices psychology.

iii. A social worker who is certified or licensed to practice psychotherapy.

iv. A paraprofessional working under the supervision of a **Provider** listed under subs. i. to iii.

v. A professional working under the supervision of a certified outpatient mental health clinic.

vi. A speech-language pathologist.

vii. An occupational therapist.

viii. A behavior analyst who is licensed under sec. 440.312, Wis. Stats.

c. For **Intensive-Level Services**, the maximum coverage provided per insured per benefit year for services:

i. Based on a treatment plan developed by a qualified **Provider** that includes at least 20 hours per week over a 6-month period of time of evidence-based behavioral intensive therapy, treatment and services, and

ii. Commencing after the **Member** is 2 years of age and before the **Member** is 9 years of age, and

iii. The majority of services are provided to the **Member** when the parent or legal guardian is present, and

iv. Does not exceed 4 cumulative years of **Intensive-Level Services**, measured from the date the **Intensive-Level Services** first commenced, and

v. Progress is assessed and documented throughout the course of treatment. Such documentation will be provided to **Unity** at its request.

d. For **Post-Intensive-Level Services**, the maximum coverage provided per insured per benefit year for services:

i. Based upon a treatment plan that includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of **Autism Spectrum Disorders**, and

ii. Progress is assessed and documented throughout the course of treatment. Such documentation will be provided to **Unity** at its request.

e. The duration required for treatment does not need to be met if it is determined by a supervising professional, in consultation with the insured's physician, that less treatment is medically appropriate.

f. The **Member** or the **Member's** authorized representative must provide notice to **Unity** if the **Member** is unable to receive **Intensive-Level Services** for an extended period of time. Such notice must indicate the reason or reasons the **Member**, the **Member's** family or care giver are unable to comply with an **Intensive-Level Services** treatment. **Unity** may not deny **Intensive-Level Services** to an insured for failing to maintain at least 20 hours per week of evidence-based behavioral therapy if notice is provided as specified in this section or if the **Member** can document that the failure to maintain at least 20 hours per week of evidence-based therapy was due to waiting for waiver program services.

4. **Behavioral Health and Chemical Dependency Services**

Covers **Medically Necessary** inpatient, outpatient, transitional treatment and **Emergency Services** for the treatment of psychiatric and nervous disorders and alcoholism and other drug abuse. Elective (**Non-Emergency**) services must be provided by **Participating Providers**.

Transitional treatment services are services for the treatment of mental **Illness**, alcoholism and other drug abuse. These are:

a. Services provided in day treatment programs by **Participating Providers** who are certified by the Wisconsin Department of Health Services (DHS).

b. Services for persons with chronic mental **Illness** provided through a community support program certified by DHS.

c. Residential treatment programs for alcohol or drug dependent persons certified by DHS.

d. Intensive outpatient programs for the treatment of psychoactive substance use disorders when provided in accordance with the patient placement criteria of the American Society of Addiction Medicine.

Transitional treatment services are subject to the same **Co-payment**, **Co-insurance**, **Deductibles** and maximum amount limitations as **Hospital Outpatient Care**

Emergency behavioral health services are covered for persons who are experiencing a behavioral health crisis or who are in a situation likely to turn into a behavioral health crisis if emergency support is not provided. Services must be provided by or through a program certified by DHS. Coverage continues until the person experiencing a behavioral health crisis is stabilized or referred to a **Participating Provider** for stabilization. **Unity** must receive notice of emergency behavioral health services within 3 business days.

Behavioral Health (Mental Health) Services coverage applies to nervous and mental disorders listed in the most current edition of the American Psychiatric Association Diagnostic and Statistical Manual. Coverage is excluded for behavior and conduct disorders, and marriage counseling.

Co-payments, **Co-insurance** and **Deductibles** may apply to **Behavioral Health and Chemical Dependency Services**. For specifics on the level of benefits and limitations for the **Contract Year**, please refer to **Your Schedule of Benefits**.

For assistance in accessing **Behavioral Health and Chemical Dependency Services**, contact Behavioral Health Care Management at (800) 683-2300.

5. Breast Reconstruction

Services include (a) mastectomy and reconstruction of the breast on which the mastectomy was performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; (c) prostheses; and (d) treatment of physical complications at all stages of the mastectomy, including lymphedema.

6. Chiropractic Services

Services must be received from a **Participating Provider**. Benefits are not available for care that is **Maintenance and Supportive Care** or **Long-term Therapy**.

7. Clinical Trials

a. Definitions

i. Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. Unity:

1. May not deny the qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition;
2. May not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and
3. May not discriminate against the individual on the basis of the individual's participation in the trial.

ii. Life-threatening condition means any disease or condition from which the likelihood of death is probable, unless the course of the disease or condition is interrupted.

iii. To be a qualifying clinical trial, a clinical trial must be approved or funded by one or more of the following:

(A) Federally funded trials:

(i) The National Institutes of Health.

(ii) The Centers for Disease Control and Prevention.

(iii) The Agency for Health Care Research and Quality.
(iv) The Centers for Medicare & Medicaid Services.
(v) cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.
(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
(vii) Any of the following if the conditions described in paragraph (2) are met:
(I) The Department of Veterans Affairs.
(II) The Department of Defense.
(III) The Department of Energy.

(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

b. Covered Benefits

Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of a life-threatening condition.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Member is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

a. Covered Health Services for which Benefits are typically provided absent a clinical trial

b. Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.

c. Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

c. Non-Covered Benefits

Routine costs for clinical trials do not include:

a. The Experimental or Investigational Service or item. The only exceptions to this are:

i. Certain *Category B* devices as defined by Center for Medicare and Medicaid Services

ii. Certain promising interventions for patients with terminal illnesses

iii. Other items and services that meet specified criteria in accordance with our medical policy guidelines.

b. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

8. Diabetic Self-Management Education

A diabetic self-management education program is covered. See "If you visit a health care provider's office or clinic" on the **Schedule of Benefits**.

9. Diagnostic Services

Radiology, laboratory and other diagnostic tests are covered when ordered by a **Participating Provider** as part of a physical examination or when authorized by **Unity**. Pap tests and pelvic examinations are **Covered Services** as deemed appropriate by a **Participating Provider**, participating Nurse Practitioner or participating Physician Assistant. Vision and hearing screenings are covered when performed to determine the need for correction. Dental x-rays are covered only when performed in conjunction with covered procedures.

Unity covers blood tests to detect lead exposure.

Screening for the presence of breast cancer and examination by low-dose mammography is covered. Diagnostic mammograms are covered as **Medically Necessary**.

Screening for colorectal cancer is covered for a **Member** 50 years of age or older and a **Member** under 50 years of age at high risk for colorectal cancer.

10. Drugs and Biologicals

Prescription Drugs are covered only when a **Prescription Drug Benefit Rider** has been made a part of this **Policy.** Coverage for **Prescription Drugs** is subject to the terms and conditions of the **Benefit Rider**. Coverage for **Prescription Drugs** is subject to the **Unity Drug Formulary** available at **unityhealth.com**. Review the **Schedule of Benefits** for specific information on the extent of coverage for this benefit.

Disposable diabetic supplies include needles, syringes, alcohol swabs, lancets, lancing devices and blood and urine test strips. Disposable diabetic supplies, **Prescription Drugs** and insulin are covered and are subject to **Unity's Drug Formulary**. If a **Prescription Drug Benefit Rider** is part of this **Plan**, diabetic testing reagents, supplies, **Prescription Drugs** and insulin are covered subject to the terms and conditions of the **Prescription Drug Benefit Rider**. If the **Prescription Drug Benefit Rider** is not part of this **Plan**, these items are covered as "**Durable Medical Equipment**" (**DME**) on the **Schedule of Benefits**.

Orally administered chemotherapy drugs are covered and are subject to **Unity's Drug Formulary**. If a **Prescription Drug Benefit Rider** is part of this **Plan**, orally administered chemotherapy drugs are covered subject to the terms and conditions of the **Prescription Drug Benefit Rider**. If the **Prescription Drug Benefit Rider** is not part of this **Plan**, these items are subject to a $100 **Co-payment** for a 30 day supply.

11. Durable Medical Equipment (DME) and Medical Supplies

Durable Medical Equipment (DME) and Medical Supplies must be **Medically Necessary** and provided by a **Participating Provider** to qualify for coverage. Enteral feedings and medical foods necessary to treat genetic disorders are covered as medical supplies.

The purchase of certain **DME** requires **Prior Authorization** to be eligible for coverage. If **You** have any questions regarding a specific item, contact **Unity** Customer Service. See Article IV, entitled "Exclusions and Limitations," for a listing of items that are excluded from coverage.

a. The following items are examples of covered **DME** (standard models only):

i. Initial acquisition of prosthetic devices including artificial limbs, face, eyes, ears and nose;

ii. Splints, trusses, crutches, orthopedic braces and appliances;

iii. Rental of mechanical equipment or the purchase of such equipment, at **Unity's** option;

iv. Initial lens(es) following cataract surgery;

v. IUDs, diaphragms and implantable contraceptives;

vi. Breast pumps; and

vii. Other medical equipment and supplies as approved by **Unity**.

b. Durable diabetic equipment includes (a) glucometers; (b) insulin infusion pumps and all supplies required for use with insulin infusion pumps; and (c) original batteries. Coverage for insulin infusion pumps is limited to one pump in a **Benefit Year** and is subject to **Medical Necessity**. **You** must use the insulin infusion pump for 30 days prior to purchase. Durable diabetic equipment is covered in the same manner as all other **DME**. Disposable diabetic supplies are covered subject to the Drugs and Biologicals section, above.

c. Foot orthotics that are custom-molded to the **Member's** foot are covered. Refer to **Your Schedule of Benefits** for details, or contact **Unity** Customer Service**.** Orthotics are limited to one pair per year.

d. Appliances and equipment will be replaced and covered provided that:

i. The item is no longer useful or has exceeded its reasonable lifetime under normal use and is still **Medically Necessary**; or

ii. The **Member's** condition has significantly changed such that the original equipment is no longer appropriate; and

iii. The replacement is not a "deluxe" model or "more advanced technology" model than required; and

iv. The replacement request has been **Prior Authorized** by **Unity**.

e. Supplies and equipment that are not primarily intended for medical use (e.g., air conditioners, exercise bicycles, filter vacuum cleaners) are not covered. Disposable medical supplies and equipment are not covered unless provided in conjunction with a **Home Health Care Services** visit.

f. **DME** and medical supplies may be subject to **Co-payment**, **Co-insurance**, **Deductibles** and maximum amount limitations. Refer to **Your Schedule of Benefits** for details or contact **Unity** Customer Service.

g. Hearing aids and cochlear implants, and the cost of treatment related to hearing aids and cochlear implants, including procedures for the implantation of cochlear devices, that are prescribed by a physician, or by an audiologist licensed under Ch. 459, Subch. II, Wis. Stats., in accordance with accepted professional medical or audiological standards are covered subject to the following conditions and limitations:

i. The **Member** must be certified as deaf or hearing impaired by a physician or audiologist.

ii. Coverage of the cost of hearing aids is limited to the cost of one hearing aid per year per **Member** once every three years.

iii. Hearing aids must be obtained from a Participating Provider and are limited to specific models. To obtain the list of covered hearing aid models log onto unityhealth.com/hearing aids or contact Unity Customer Service.

iv. Costs of treatment related to hearing aids such as ear molds and fittings are only covered when the hearing aid model is covered.

v. Hearing aids are subject to the **Co-payment**, **Co-insurance**, **Deductibles** and maximum amount limitations for DME.

Benefits under this section do not include bone anchored hearing aids, except that bone anchored hearing aids are covered for:

i. **Members** with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.

ii. For **Members** with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

12. Emergency Services

Services for the treatment of accident, **Injury** or sudden **Illness** are covered when provided at the nearest emergency room.

Review **Your Schedule of Benefits** to determine if a **Co-payment** or **Co-insurance** applies. If **You** are admitted for an inpatient hospitalization directly from the emergency room, the **Emergency Room Co-payment** will be waived and the **Hospital Services Benefit** applies.

Services recommended as follow-up to emergency treatment are not covered as **Emergency Services**. **Prior Authorization** for follow-up services is required unless the services are provided by **Your Primary Care Physician**.

13. Extraction and Replacement of Sound Natural Teeth Because of Accidental Injury

Benefits are for repair of **Sound Natural Teeth**, or extraction and replacement of non-restorable natural teeth, damaged due to trauma to the teeth or jaw. Treatment must begin within 90 days after the accident and will be covered for a maximum of 12 months after treatment begins. Chewing accidents and dental implants are not covered by this provision.

14. Habilitative Services

Medically Necessary physical and occupational therapy, speech-language pathology, other services, and habilitative devices for people with disabilities. Vocational therapy and custodial services are not covered.

15. Home Health Care Services

a. **Home Health Care Services** means care and treatment of a **Member** under a plan of care. These services must consist of one or more of the following:

i. Part-time or intermittent home nursing care by, or supervised by, a registered nurse;

ii. Part-time or intermittent home health aide services that are **Medically Necessary** as part of the home care plan. Services must be supervised by a registered nurse or medical social worker and consist of caring for the patient;

iii. Physical, respiratory, occupational and speech therapy provided by a registered therapist. (See "Therapy Services" in this section);

iv. Medical supplies, drugs and medications prescribed by a **Physician**, and laboratory services performed by or on behalf of a **Hospital**, if necessary under the home care plan. These supplies and services are covered to the extent that they would be covered if the **Member** were hospitalized;

v. Nutrition counseling provided or supervised by a registered or certified dietitian. Such services must be **Medically Necessary** as part of the home care plan;

vi. Evaluation of the need for and development of the home care plan. Evaluation must be provided by a registered nurse, physician extender or medical social worker, and approved or requested by the **Attending Physician**.

b. The home care plan must be established, approved in writing and reviewed by the **Attending Physician**.

c. **Home Health Care Services** must be **Prior Authorized** by **Unity**. **Home Health Care Services** will not be covered unless the **Attending Physician** submits a treatment plan to **Unity**. The treatment plan must certify all of the following:

i. Hospitalization or **Confinement** in a **Skilled Nursing Facility** would otherwise be needed if **Home Health Care Services** were not provided;

ii. Necessary care and treatment are not available from the **Member's Immediate Family** or other persons living with the **Member** without causing undue hardship; and

iii. The **Home Health Care Services** will be provided or coordinated by a state-licensed or **Medicare**-certified home health agency or certified rehabilitation agency.

d. If the **Member** was hospitalized immediately before **Home Health Care Services** began, then the home care plan will initially be approved by the **Physician** who was the primary **Provider** of care while the **Member** was hospitalized. Up to 4 consecutive hours in a 24-hour period of **Home Health Care Services** will be considered as one home health care visit.

16. Hospice Care

Unity will provide **Hospice Care** if such care is determined to be **Medically Necessary** and is **Prior Authorized** by **Unity**.

17. Immunizations and Allergy Injections

For children from birth to age 6 years, the following immunizations are covered and not subject to **Deductibles, Co-insurance** and **Co-payments**: Diphtheria, Pertussis, Tetanus, Polio, Measles, Mumps, Rubella, Hemophilus influenza B, Hepatitis A, Hepatitis B, Varicella, influenza, Pneumococcal conjugate, and Rotavirus.

For all other **Members**, appropriate and necessary Immunizations and allergy injections.

18. Maternity Services

Prenatal and postnatal care and treatment are covered. The **Member** is entitled to inpatient **Hospital** services for up to 48 hours following a vaginal delivery and up to 96 hours following a cesarean section.

Care received outside the **Service Area** during the 9th month of pregnancy will not be covered unless it is an emergency. A normal full-term delivery is not considered to be an **Emergency Medical Condition**.

19. Nurse Practitioner and Physician Assistant Services

Services performed by nurse practitioners and physician assistants are covered when performed under the supervision and guidance of a **Participating Provider**.

20. Oral Surgery Services

Covered oral surgery procedures are:

a. Surgical removal of bony or tissue-impacted teeth.

b. Removal of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth.

c. Removal of apex of tooth root (apicoectomy).

d. Removal of exostoses of the jaw and hard palate.

e. Treatment of fractured jaw and facial bones due to an accident.

f. External and internal incision and drainage of cellulitis.

g. Cutting of accessory sinuses, salivary glands or ducts.

h. Frenectomy.

i. Vestibuloplasty (surgical modification of the gingival-mucous membrane relationship in the vestibule of the mouth).

j. Residual root removal; root amputation.

These services also include diagnostic radiology by a dentist or oral surgeon when ordered in conjunction with a covered surgery. There are no benefits for: (a) extraction of teeth by pulling;

(b) root canal procedures; (c) filling, capping or recapping of teeth; (d) mandibular and/or maxillary osteotomy; or (e) dental implants.

21. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

a. Pouches, face plates and belts

b. Irrigation sleeves, bags and ostomy irrigation catheters

c. Skin barriers

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

22. Preventive Health Services

Preventive Health Services are covered upon renewal 12 months after publication of the recommendation or guideline. **Preventive Health Services** not subject to **Deductibles, Co-insurance** and **Co-payments**.

23. Primary Care Physician Services

Services provided by the **Primary Care Physician (PCP)** for the treatment of **Illness** or **Injury** and preventive care.

24. Radiation Therapy and Chemotherapy

Generally accepted therapeutic methods, such as radiology, radium or radioactive isotopes when performed and billed by a **Participating Provider**.

25. Routine Foot Care

Procedures such as removing corns or calluses, nail trimming and other routine hygiene care of the foot are covered only when performed by the **Primary Care Physician**. However, diabetic **Members** may obtain routine foot care from a **Participating** specialist.

26. Second Opinion

Unity covers a second opinion from another **Participating Provider**. **Prior Authorization** is required for a second opinion from a **Non-Participating Provider**.

27. Surgical Services

Recognized surgical procedures are covered, including, but not limited to, the following:

a. Pre-operative and post-operative care and the services of assistants and consultants that are necessary for the treatment of **Illness** and **Injury**;

b. Elective sterilization procedures;

c. Medically recognized procedures performed as an alternative to surgery; and

d. Mastectomy and reconstruction of the breast on which the mastectomy was performed and reconstruction of the other breast to produce a symmetrical appearance.

28. Temporomandibular Joint Treatment (TMJ)

a. Diagnostic procedures and surgical and non-surgical treatment for the correction of temporomandibular joint disorders. The treatment must be **Medically Necessary** and all of the following criteria must apply:

i. The condition is caused by **Congenital**, developmental or acquired deformity, disease or **Injury**; and

ii. Under the accepted standards of the profession of the **Participating Provider** rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition; and

iii. The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

b. For purposes of this section only, non-surgical treatment may include intra-oral splint and therapy devices and appliances. These items are covered as **Durable Medical Equipment (DME)**.

c. Surgical procedures for the correction of functional deformities or malocclusion of the mandible and maxillae are excluded (e.g., mandibular/maxillary osteotomy). C**overed Services** under this section are subject to certain exclusions and limitations. A **Participating Provider** must provide these services. Review Article IV, entitled "Exclusions and Limitations" for additional information.

29. Therapy Services

a. Outpatient Physical, Occupational, Speech and Hearing Therapy
Refer to the **Schedule of Benefits** for specific levels of coverage.

b. Cardiac Rehabilitation Therapy
Cardiac rehabilitation therapy services are covered for eligible **Members** with a recent history of heart attack (myocardial infarct), coronary artery bypass graft (CABG), onset of stable angina pectoris, onset of decubiti angina, heart valve surgery, PTCA and cardiac transplant.

Benefits are payable only for an eligible **Member** for one of the seven covered conditions. Refer to the **Schedule of Benefits** for specific levels of coverage. Benefits are not payable for behavioral or vocational counseling and maintenance cardiac rehabilitation. Phase IV cardiac rehabilitation is not covered.

c. Inpatient Therapy
Benefits are payable for inpatient medical rehabilitation (not chemical dependency or alcohol and other drug abuse). Refer to the **Schedule of Benefits** for specific levels of coverage.

d. Post cochlear implant aural therapy

Long-term Therapy and **Maintenance and Supportive Care and/or Therapy** are not **Covered Services**.

30. Transplant and Related Surgical Services

Benefits are payable for organ or tissue transplant services. The **Charges** must be incurred during a transplant benefit period that begins with the initial transplant evaluation while a **Member** is insured under this **Plan**. The **Charges** must be due to an **Injury** or **Illness** covered by this benefit as determined by **Unity**. The transplant procedure must be performed at a **Hospital** designated by **Unity**. This applies to all **Plan Benefits** covered under this section. All transplant services and treatments require **Prior Authorization**.

"Covered transplant procedure" means any of the following human-to-human organ or tissue transplants: cornea, heart, lung, heart with lung, liver, kidney, kidney with pancreas, and bone marrow (e.g., peripheral stem and cord blood). Bone marrow transplant for the treatment of solid tumors in adults is not covered.

"Recipient" means the insured person who receives an organ or tissue transplant.

"Organ or tissue transplant services" means the following as it relates to a covered transplant procedure: (1) organ and tissue procurement (consists of removing, preserving and transporting the donated part, as well as tissue-typing for related or unrelated donors), (2) **Hospital** room and board and medical supplies, and (3) diagnosis, treatment, surgery and follow-up care by a **Physician**, including dressings and supplies.

a. Donor Services

Donor services are covered only if the recipient is a **Member**.

b. Special Exclusions and Limitations Applicable to Transplant Services

Benefits are not payable for the following:

i. Services not ordered by a **Physician**.

ii. Services for which a **Member** has no legal obligation to pay in the absence of insurance.

iii. Services for an **Injury** or **Illness** due to employment with an employer or self-employment that are otherwise covered by a worker's compensation or other occupational disease law.

iv. Custodial Care.

v. Services for bone marrow transplants for the treatment of solid tumors in adults, and other transplants not indicated as covered transplant procedures.

vi. Services received from a facility or **Provider** not **Prior Authorized** by **Unity.**

vii. Artificial organ implant procedures.

viii. More than one transplant per organ or tissue per **Member** during the lifetime of the **Policy** with **Unity**, except as required by law (e.g., the treatment of kidney disease).

31. Urgent Care Services

Urgent Care Services for the treatment of an accident, **Injury** or **Illness** are covered when provided by a **Participating Provider** or urgent care facility. If **You** require **Urgent Care Services**, call **Your Primary Care Physician** for instructions if possible. Otherwise seek care at the nearest urgent care facility. Follow-up treatment will not be covered as **Urgent Care**

Services. Follow-up treatment is subject to the same **Referral** and **Prior Authorization** requirements as elective services.

If **You** receive **Urgent Care Services** from a **Non-Participating Provider**, **You** must notify **Unity** within 3 business days of receiving the services, or as soon thereafter as is medically feasible, whichever is later. Contact **Unity** Customer Service to provide this notice.

*If **You** fail to provide the required notice, **Your** benefit may be reduced by 50% of the **Covered Expense** or $250, whichever is less.* This penalty will not apply toward satisfaction of **Your Deductible** or **Out-of-Pocket** limit. This penalty will not reduce state mandated benefits.

32. Vision Services

The first visit each calendar year for routine eye care provided by a **Participating** vision care specialist is covered for all **Members**.

B. Hospital Services Benefit

Inpatient and outpatient services from a **Participating** facility that are necessary for admission, diagnosis and treatment are covered. Services received from a **Non-Participating** facility are covered if **Prior Authorized** by **Unity** or if the services are rendered due to an **Emergency Medical Condition**. Facility charges for dental anesthesia are covered.

1. Inpatient Care

a. Hospitals and Specialty Hospitals

Benefits are for semi-private room, ward or intensive care unit and necessary and reasonable ancillary **Hospital Charges**. A private room is covered if **Unity** determines it is **Medically Necessary.**

b. Licensed Skilled Nursing Facility

i. The **Member** must be admitted within 24 hours of discharge from a **Hospital** for continued treatment of the same condition. Care must be **Skilled Nursing Care**. The daily rate payable under this benefit will be at least the daily minimum rate established for licensed **Skilled Nursing Care Facilities** by the Wisconsin Department of Health Services. Coverage under this benefit applies only to **Skilled Nursing Care** that is:

(1) Certified as **Medically Necessary** by **Unity**; and

(2) Re-certified as **Medically Necessary** every 7 days.

ii. Coverage is for the continued treatment of the same condition for which the **Member** was treated in the **Hospital** before entry into the **Skilled Nursing Facility**. There is no coverage for care that is:

(1) Essentially domiciliary or **Custodial Care**;

(2) Available to the **Member** without charge; or

(3) Paid for under a governmental health care program other than **Medicaid**.

c. **Nervous and Mental Disorders and Alcoholism and Drug Abuse Confinements**
See **Behavioral Health and Chemical Dependency Services** in this Article and the **Schedule of Benefits** for details.

2. **Outpatient Care**

a. **Emergency Room**
Emergency Services are those services that are necessary to treat an **Emergency Medical Condition**. **Emergency Services** include both professional and facility components. Follow-up care provided subsequent to the emergency by a **Non-Participating Provider** is not covered unless **Prior Authorized**.

b. **Ambulatory Surgical Care**
These are services provided in an outpatient setting. Unless specifically authorized in this **Certificate,** services may require **Prior Authorization**.

c. **Behavioral Health (Mental Health) Services**
See **Behavioral Health and Chemical Dependency Services** in this Article and the **Schedule of Benefits** for benefit details.

d. **Diagnostic Testing**
Includes laboratory, radiology and other diagnostic tests.

e. **Clinic Visits**
Physician services and facility services associated with immunizations and well-child care.

ARTICLE IV: EXCLUSIONS AND LIMITATIONS

A. Exclusions

This **Plan** does not provide coverage for the following:

1. Surgical Services

a. Procedures to correct obesity, treat the complications or co-morbidities of obesity or treat gastroesophageal reflux disease. Also excluded are treatments of complications arising from such procedures and removal of excess skin resulting from weight loss.

b. Plastic or cosmetic surgery, including Chemical Peel, undertaken solely to improve the **Member's** appearance.

c. **Reconstructive Surgery** unless the purpose is to correct a functional defect.

d. Breast augmentation and any treatment for complications resulting from these procedures. This **Exclusion** does not apply to the reconstruction of affected tissue incident to a mastectomy or for complications of mastectomy, including lymphedema

e. Kerato-refractive eye surgery including, but not limited to, tangential or radial keratotomy.

f. Removal of skin tags.

g. Penile implants.

2. Medical Services

a. Examinations and assessments required for employment, participation in sports, licensing, education or insurance; or any third-party request, including court-ordered treatment that does not otherwise qualify for coverage.

b. Immunizations covered or requested by an employer, educational institution or other third party.

c. Expenses for the preparation and presentation of medical reports and records.

d. Nutritional counseling and weight control programs, except for counseling by a **Primary Care Physician**.

e. Neuropsychological testing for educational purposes.

f. **Custodial Care** and **Maintenance and Supportive Care and/or Therapy** and **Long-term Therapy**.

g. Sublingual (under the tongue) allergy testing and/or treatment.

h. Any health care service, item or investigational drug that is the subject of a clinical trial; any health care service, item or drug provided solely to satisfy data collection and analysis needs that is not used in the direct clinical management of the patient; an investigational drug or device that has not been approved for marketing by the United States Food and Drug Administration (FDA); transportation, lodging, food or other expense for the patient, family

member or companion of the patient that is associated with travel to or from a facility providing the clinical trial; any service, item or drug provided by the clinical trial sponsor free of charge for any patient; or any service, item or drug that is eligible for reimbursement by an entity other than **Unity**, including the sponsor of the clinical trial.

3. Ambulance Services

Travel and transportation for a consultation or to receive non-emergent treatment, except for approved ambulance service.

4. Therapies

a. Long-term Therapy and Maintenance and Supportive Care and/or Therapy for chronic conditions. Therapies of this type include, but are not limited to: general exercise programs, maintenance exercise programs, physical conditioning programs, massage therapy, assistance with activities of daily living, and any therapy services that **Unity** determines are not **Medically Necessary**.

b. Physical, speech and occupational therapy are not covered for the following conditions: malocclusion, perceptual disorders, and sensory deficit disorders. Also excluded are testing and treatment related to these conditions.

c. Physical therapy services for athletic performance enhancement purposes.

d. Services for the treatment of behavior/conduct disorders and marriage counseling.

e. Vocational rehabilitation, including work-hardening programs.

f. Biofeedback.

g. Massage therapy.

h. Prolotherapy that is not **Medically Necessary** and has not been **Prior Authorized**.

5. Oral Surgery and Dental Services

a. All dental procedures, including, but not limited to, examination, care, treatment, filling, removal, restoration or replacement of teeth, Oral surgery procedures related to the correction of functional deformities of the mandible or maxillae; procedures that shorten, lengthen or reposition the mandible or maxillae; procedures to correct malocclusion; Dental implants, and any oral surgical procedure not listed as a benefit under Article III.This **Exclusion** does not apply to covered oral surgery procedures or covered dental services required because of accidental **Injury**.

6. Transplants

a. Transplants not listed as a covered benefit under Article III.

b. Follow-up care related to non-covered transplant procedures.

c. Medical or other costs related to the donation of organ(s) intended for a person who is not a **Unity Member**.

d. Anti-rejection and immuno-suppressive drugs for non-covered transplant procedures.

7. Reproductive Services

a. **Infertility** services which are not for treatment of **Illness** or **Injury** (i.e., that are for the purpose of achieving pregnancy). The diagnosis of **Infertility** alone does not constitute an **Illness**.

b. Fertility and **Infertility** treatments. Services related to intrauterine insemination (IUI), in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) or any other similar means of achieving pregnancy. Services that diagnose **Infertility** are covered up to the time that treatment begins. Once treatment begins, diagnostic and evaluative services are not covered. No fertility drug, whether given in the **Physician's** office or received from a pharmacy, is covered.

c. Reversal of voluntary sterilization procedures and related procedures.

d. **Charges** related to surrogate mother services.

e. Home delivery for childbirth.

f. Contraceptive medications or devices that are available without a prescription, except when the medication or device is both FDA-approved and prescribed by a **Provider**.

g. Services for storage or processing of semen (sperm); donor sperm; harvesting of eggs and their cryopreservation; surrogate mother services.

8. Hospital Inpatient Services

a. Personal comfort or convenience items, including but not limited to, television, telephone, housekeeping and homemaker services. **Charges** for a private room will not be covered unless **Medically Necessary**.

b. **Hospital Charges** for services not covered under Article III of this **Policy**.

9. Outpatient Prescription Drugs

a. **Prescription Drugs**, unless the **Prescription Drug Rider** is made a part of this **Plan**. This does not exclude orally administered chemotherapy drugs, diabetic insulin and supplies as listed on **Unity's Drug Formulary**.

b. **Prescription Drugs** prescribed for cosmetic purposes or for conditions or treatments that are not covered benefits under this **Policy** (for example, **Prescription Drugs** related to **infertility** treatment or the treatment of obesity).

c. Take-home **Prescription Drugs** and supplies dispensed at the time of **Hospital** discharge that can be purchased on an outpatient basis, whether billed directly or separately by the **Hospital**.

d. **Prescription Drugs** not approved by the FDA.

10. Durable Medical Equipment (DME) and Disposable Medical Supplies

a. Equipment, appliances, devices and supplies that are not prescribed to treat **Illness** or **Injury**. Examples include safety equipment, such as helmets, some braces and safety seats.

b. The repair or the replacement of **Durable Medical Equipment (DME)**, other than those items that are covered as specified in Article III. Also excluded is the repair and replacement of **DME** that is covered by a homeowner's insurance policy or other similar policy.

c. Eyeglasses and contact lenses and fittings for contact lenses, the first pair of corrective lenses following cataract surgery or for the treatment of keratoconus are covered. Specialty intraocular lenses (over the cost of a standard monofocal intraocular lens) implanted at the time of cataract surgery or as a separate subsequent surgical procedures. Specialty intraocular lenses include, but are not limited to: toric astigmatism-correcting intraocular lenses and multifocal presbyopia-correcting intraocular lenses.

d. Orthopedic shoes, unless they are part of a brace. Orthopedic shoes may be covered for diabetics if **Prior Authorized** by **Unity**.

e. Replacement of lost, or repair of broken, corrective appliances resulting from negligence or abuse.

f. Optional accessories or devices primarily for the **Member's** comfort or convenience; footwear; and orthodontic devices.

g. Elastic support stockings that are not **Medically Necessary;** foot pads; bunion covers; batteries; antiseptics; tape; over-the-counter shoe inserts; supports; and elastic bandages.

h. Customization of vehicles and/or lifts for wheelchairs and/or scooters.

i. Any and all types of modifications to the **Member's** home and items associated with such modifications (for example, ramps, grab bars, stair lifts and chair lifts).

j. Items that are generally considered to be comfort or convenience items, such as shower chairs, tub transfer benches, home UV therapy units, and home monitoring devices (for example, blood pressure cuffs and INR monitors).

k. Bone anchored hearing aids except when either of the following applies:

i. For **Members** with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.

ii. For **Members** with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

More than one bone anchored hearing aid per **Member** who meets the above coverage criteria during the entire period of time the **Member** is enrolled under the Policy.

l. Alternative communication devices (for example, electronic keyboard for a hearing impairment, computers, hand-held phones or devices).

m. Penile implants and other erection devices.

11. General

a. Any service that is not **Medically Necessary**. Any service that is not required in accordance with accepted standards of medical, surgical or psychiatric practice. **Hospital** stays extended for reasons other than **Medical Necessity** are not covered and become the **Member's** responsibility for payment. For example, inclement weather, lack of transportation, lack of a caregiver at home and other social reasons do not justify coverage for an extended **Hospital** stay.

b. Services obtained which require **Prior Authorization**, in which the **Member** did not receive **Prior Authorization** are not covered. Any treatment, services, and supplies in excess of what is **Prior Authorized**.

c. Any service for which the **Member** refuses to authorize or provide for the release of medical information, including: names of all **Physicians** and **Providers** from whom **You** received medical attention; information regarding the circumstances of **Your Injury.**

d. **Experimental or Investigative** treatment, services, devices and supplies.

e. Nutritional supplements and special feedings; meal services that are part of a Home Health Care program.

f. Services rendered by a masseuse or massage therapist.

g. Hypnotherapy and acupuncture.

h. Orthoptics (eye exercise-training programs).

i. Private duty nursing.

h. **Custodial**, domiciliary or convalescent care that does not require **Skilled Care.**

i. Coma stimulation programs.

j. Treatment for compulsive gambling (for example, pathological gambling or gambling addiction).

k. Hypnotherapy, acupuncture and laser treatment for smoking cessation.

l. Services that **Unity** has no legal obligation to cover, such as services provided by free clinics and government programs.

m. Charges for services or items that the **Member** has no legal obligation to pay.

n. Services available under a federal, state, county, municipal or other governmental agency or law now existing, or subsequently enacted or amended, such as **Medicare** and Veterans Administration programs covering service-connected disabilities or conditions; services available under "No-Fault" automobile insurance; services related to any **Illness** or **Injury** covered by a Worker's Compensation Act or employer liability law; also excluded are services to treat an **Injury** or **Illness** arising from, or incurred during the course of, any employment for wage or profit.

o. Health and benefit expenses incurred before coverage under this **Policy** begins and after coverage or eligibility terminates.

p. Any federal, state or local taxes due on benefits, goods or services; shipping and handling charges.

q. Services required while incarcerated in a federal, state or local penal institution, or services required while in custody of federal, state or local law enforcement authorities.

r. Any condition, disability or **Charge** resulting from or sustained as a result of being engaged in an illegal occupation or the commission or attempted commission of an assault or a criminal act.

s. Services provided to or received by a **Member** as a collateral medical procedure in connection with the treatment of any person who is not a **Member**.

t. Services, care or treatment for medical complications resulting from or associated with non-covered services.

u. Any treatment or service rendered by, or at the direction of, a person residing in **Your** home or rendered by a member of **Your Immediate Family** or any other person related to **You** or a **Dependent** in a similar fashion.

v. Treatment, services and supplies not specifically identified by **Unity** as being covered.

w. Expenses related to repatriation and medical evacuation.

x. Travel expenses including but not limited to rental car services, tolls, mileage reimbursement, gas, lodging, food, and airfare.

y. Hair removal.

z. Any items offered over the counter that are not otherwise listed as covered in **Your Policy** documents.

B. Limitations

1. Major Disaster or Epidemic

If a major disaster or epidemic occurs, **Physicians** and **Hospitals** will render medical services and arrange for extended care services and **Home Health Care Services** as is practical according to their best medical judgment and within the limitation of available facilities and personnel. Neither **Unity** nor any **Plan Provider** shall incur any liability or obligation for delay or failure to provide or arrange for medical services that the disaster or epidemic renders unavailable.

2. Circumstances Beyond the Control of Unity

Covered Services may be delayed or made impractical by circumstances not reasonably within **Unity's** control, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, disability of a significant part of **Hospital** or medical group personnel or similar causes. If services are delayed or made impractical, **Unity** and its **Plan Providers** will use their best efforts to provide services and benefits covered under this **Policy**, but neither **Unity** nor any **Plan Provider** shall incur any liability or obligation for failure to provide services or other benefits.

3. Treatment of Growth Retardation

Treatment of growth retardation is covered only when 1) the **Prescription Drug Rider** is part of this **Plan**; and 2) production of the growth hormone is absent due to pituitary gland loss or failure. Coverage is not extended for short stature syndrome or other related growth abnormalities.

4. Proof of Claim

You must submit proof of **Claim** within 90 days of the date of service. Circumstances beyond **Your** control might make this time limit unreasonable. If so, **You** must file the **Claim** as soon as possible, and Pursuant to sec. 631.81, Wis. Stats., **We** will still process **Your Claim** if **You** submit it within one year after the time required under this provision.

If **You** are submitting **Claims** for which **You** have already paid, and **You** are seeking **Unity's** reimbursement, you must provide proof of payment. The bill or receipt from your provider must match the service that **You** are seeking **Unity's** reimbursement for.

5. Emergency Services

Follow-up care provided subsequent to the emergency by a **Non-Participating Provider** is not covered unless **Prior Authorized**. Medical treatment that **You** receive on an emergency basis for an **Illness** or an **Injury** that is not an **Emergency Medical Condition** will not be considered a **Covered Service**.

6. Urgent Care Services

If **You** need **Urgent Care Services**, call your **Primary Care Physician** for instructions if possible. Otherwise seek care at the nearest urgent care facility. If **You** receive **Urgent Care Services** from a **Non-Participating Provider**, **You** must notify **Unity** within 3 business days following the date of service or as soon thereafter as is medically feasible, whichever is later. Contact **Unity** Customer Service to provide this notice.

*If **You** fail to provide the required notice, **Your** benefit may be reduced by 50% of the **Covered Expense** or $250, whichever is less.* This penalty will not apply toward **Your Deductible** or **Out-of-Pocket** limit.

7. Primary Care Physician Selection

A **Primary Care Physician (PCP)** is a licensed **Physician** who has been designated by **Unity** to provide primary health care services to its **Members**. Each **Member** is required to select a **PCP** from a list that can be found at Find A Doctor at unityhealth.com or in the **Provider Network Directory**. The **PCP** provides the full range of primary health care services which are ordinarily provided by General Practitioners, Internists, Family Practitioners, Pediatricians, OB/GYN **Physicians** and Geriatricians.

8. Specialty Providers

You must use a **Participating Provider** for specialty care. All specialty services must be **Medically Necessary** and a **Covered Service** under the **Plan**.

Referrals are not necessary to access the following services: Chiropractic, Emergency Care, Oral Surgery, OB/GYN **Physician** services and optometrist services. **Unity** encourages **You** to ask **Your** oral surgeon to submit a pre-treatment plan before services are rendered to determine whether the services are **Covered Services**.

For assistance in accessing **Behavioral Health and Chemical Dependency** services, contact Behavioral Health Care Management at (800) 683-2300.

9. Changing Your Primary Care Physician

You may change **Your PCP** by logging on to **unityhealth.com** or by contacting **Unity** Customer Service. The change will be effective no later than the first day of the following month as long as the new **Physician** is accepting additional patients.

10. Out-of-Pocket Costs

Your Schedule of Benefits includes details relating to **Co-payments, Co-insurance** and **Deductibles** which may apply to office visits, specialty visits, inpatient **Hospital** stays, **Emergency Room** visits and urgent care facility visits. **Your Schedule of Benefits** identifies the amount of **Co-payment, Co-insurance** and/or **Deductible** applicable to **Your Plan**.

11. Other Limitations

In addition to the limitations set forth in this **Certificate of Coverage**, see the limitations in **Your Schedule of Benefits**.

ARTICLE V: COORDINATION OF BENEFITS

If **You** have health care coverage through another group program or individual policy, **Unity** will coordinate the payment of benefits in accordance with applicable law and as set forth in this **COB** provision. The purpose of this provision is to ensure that **You** receive the benefits to which **You** are entitled without providing more benefits than the total cost of care received.

A. Definitions

1. **Allowable Expense** means any necessary, reasonable and customary item of expense for health care, at least a portion of which is covered under one or more **Plans** covering the person for whom the **Claim** is made.

The difference between the cost of a private **Hospital** room and the cost of a semi-private **Hospital** room is not considered an **Allowable Expense** unless the patient's stay in a private **Hospital** room is **Medically Necessary**, either in terms of generally accepted medical practice or as specifically defined in the **Plan**.

When a **Plan** provides benefits in the form of services, the reasonable cash value of each service provided shall be considered both an **Allowable Expense** and benefit paid.

2. **Claim Determination Period** means a **Contract Year**. However, it does not include any part of a year during which a person has no coverage under this **Plan** or any part of a year before the date this **COB** provision or similar provision takes effect.

3. For purposes of this **COB** section only, a **Plan** means any of the following which provide benefits or services for, or because of, medical or dental care or treatment.

a. **Group** insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes pre-payment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

b. Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under **Medicaid**. It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.

4. This **Plan** means the **Group Health Plan** offered by **Unity** and described in this **Policy**.

B. Effect of Benefits

Unity will apply these provisions when **You** incur **Allowable Expenses**, during a **Claim Determination Period**, for which benefits are payable under any other **Plan**. The provisions will apply only when the sum of the **Allowable Expenses** under this **Plan** and any other **Plan** would, in the absence of this **COB** provision or any similar provision in the other **Plan**, exceed the **Allowable Expenses**.

Benefits provided under **This Plan** during a **Claim Determination Period** for **Allowable Expenses** incurred will be determined as follows:

1. If benefits under **This Plan** are to be paid after any other **Plan**, the benefits under **This Plan** will be reduced so total benefits payable by all **Plans** will not exceed the total of the **Allowable Expenses**.

2. If benefits under **This Plan** are to be paid before benefits are paid under any other **Plan**, benefits under **This Plan** will be paid without regard to the other **Plan**.

Allowable Expenses under any other **Plan** include the benefits that would have been payable had a **Claim** been duly made.

Reimbursement will not exceed 100% of the total **Allowable Expenses** incurred under **This Plan** and any other **Plan** included under this provision.

C. Order of Benefit Determination

For the purpose of the effect of benefits provision above, the rules establishing the order of benefit determination are as follows:

1. Non-dependent/Dependent

The benefits of a **Plan** which covers the person on whose expenses the **Claim** is based other than as a **Dependent** shall be determined before the benefits of a **Plan** which covers such person as a **Dependent**.

2. Dependent Child/Parents Not Separated or Divorced

The benefits of a **Plan** which covers the person on whose expense the **Claim** is based as a **Dependent Child** are determined according to which parent's birth date occurs first in a calendar year, excluding the year of birth. If both parents have the same birthday, the **Plan** that has covered a parent longer pays before the **Plan** that has covered a parent for any shorter period of time.

3. Dependent Child/Separated or Divorced Parents

If two or more **Plans** cover a person as a **Dependent Child** of divorced or separated parents, benefits for the **Child** are determined in this order:

a. When parents are separated or divorced and the parent with custody of the **Child** has not remarried, the benefits of a **Plan** that covers the **Child** as a **Dependent** of the parent with custody of the **Child** will be determined before the benefits of a **Plan** that covers the **Child** as a **Dependent** of the parent without custody.

b. If two or more **Plans** cover a person as a **Dependent Child** of divorced or separated parents and the parent with custody of the **Child** has remarried, benefits for the **Child** are determined in the following order:

i. First, the **Plan** of the parent with custody of the **Child**;

ii. Then, the **Plan** of the spouse of the parent with custody of the **Child**; and

iii. Finally, the **Plan** of the parent not having custody of the **Child**.

c. Notwithstanding provisions "a" and "b" above, if the specific terms of a court decree state that the parents have joint custody of the **Child** and do not specify that one parent has responsibility for the **Child's** health care expenses, or if the court decree states that both parents shall be responsible for the health care needs of the **Child** but gives physical custody of the **Child** to one parent, and the entities obligated to pay or provide the benefits of the respective parent's **Plans** have actual knowledge of those terms, benefits for the **Dependent Child** shall be determined according to par. C.2., above.

d. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the **Child**, and the entity obligated to pay or provide the benefits of the **Plan** of that parent has actual knowledge of those terms, the benefits of that

Plan are determined first. This paragraph does not apply with respect to any **Claim Determination Period** or **Benefit Year** during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. Active/Inactive Employee

When rules 1, 2 and 3 above do not establish an order of benefits determination, the benefits of a **Plan** that has covered such person as a laid-off or retired **Employee** or as the **Dependent** of the person are determined after the benefits of a **Plan** that has covered such person through present employment.

5. Longer/Shorter Length of Coverage

When rules 1, 2, 3 and 4 above do not establish an order of benefits determination, the benefits of a **Plan** that has covered the person for the longer period of time are determined before the benefits of a **Plan** that has covered the person for the shorter period of time.

Whenever one **Plan** does not contain a **COB** provision, that **Plan** must pay its benefits before any other **Plan** pays.

When these provisions reduce the total amount of benefits otherwise payable to **You** under **This Plan** during any **Claim Determination Period**, each benefit that would be payable in the absence of this provision is reduced proportionately and such reduced amounts are charged against any applicable benefit limit under **This Plan**.

6. Continuation of Coverage

If a person has continuation coverage under Federal or State law and is also covered under another **Plan**, the **Plan** covering the person as an **Employee**, **Member** or **Subscriber** or as a **Dependent** of an **Employee**, **Member** or **Subscriber** is primary and the continuation coverage is secondary.

D. Right to Receive and Release Necessary Information

Unity may require certain information in order to apply and coordinate these provisions with other **Plans**. To get the needed information, **Unity** may, without **Your** consent, release or obtain from any insurance company, organization, or person information needed to implement this provision. **You** agree to notify **Unity** of the existence of any other group coverage that **You** have and to furnish any information **Unity** needs to apply these provisions.

E. COB with Medicare

In all cases, **COB** with **Medicare** will conform with Federal and State statutes and regulations. If **You** are eligible for **Medicare** benefits, but not necessarily enrolled, **Your** benefits under **This Plan** will be coordinated to the extent benefits otherwise would have been paid under **Medicare** as allowed by Federal and State statutes and regulations. Except as required by Federal and State statutes and regulations, **This Plan** will pay benefits on a secondary basis to **Medicare**.

F. Facility of Payment

A payment made under another **Plan** may include an amount that should have been paid under **This Plan**. If this occurs, **Unity** may pay that amount to the organization that made that payment. That amount will then be treated as if it were a benefit paid under **This Plan**. **Unity** will be fully discharged from liability under **This Plan** to the extent of any payment so made. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right to Recovery

Unity reserves the right to recover any payment made for an **Allowable Expense** under **This Plan** in the amount by which the payment exceeds the maximum amount **Unity** is required to pay under these provisions.

This right of recovery applies to **Unity** against the following:

1. Any person(s) to, for or with respect to whom, such payments were made; or

2. Any other insurance company or organization which, according to these provisions, owes benefits due for the same **Allowable Expense** under any other **Plan**.

Unity shall determine against whom this right of recovery will be exercised.

ARTICLE VI: ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

A. Employee Coverage

1. Eligibility

An **Employee** must reside or work in the **Service Area**. **Unity** considers an **Employee's** "residence" to be the location in which he/she spends at least 9 months out of a 12-month period. Eligibility for coverage begins on the date an **Employee** meets all eligibility criteria specified on the **Group Application**.

2. Enrollment and Effective Date

An **Employee** may apply for enrollment in the **Plan** by submitting a completed **Enrollment Application Form** and, if necessary, an **Employer's Certification of Group Health Plan Coverage**, or other acceptable documentation as indicated by federal law. Application must be made during an annual enrollment period or within 31 days of becoming eligible. The **Enrollment Form** may be obtained from the **Group's** benefit administrator.

Unity, at its discretion and with the mutual agreement of the employer, may allow for an **Open Enrollment Period** or a **Dual Choice Enrollment Period**.

3. New Entrant

A new entrant may enroll within 31 days from the date he/she is eligible to enroll and will be covered on the date **Unity** specifies. A new entrant is an **Employee** who becomes part of the **Group** after the first enrollment period.

4. Late Applicant

If an **Employee** is a **Late Applicant** who is not entitled to enroll during a **Special Enrollment**, then the **Employee** will be enrolled in the **Plan** as of the date of application and subject to a 12-month **Waiting Period**. The **Effective Date** will be delayed by 12 months or that period of time up to the **Open Enrollment Period**, if any, whichever comes first, and coverage will be effective as of that date.

5. Late Applicant/Special Enrollment

An **Employee** is a **Late Applicant** if he or she has previously waived or otherwise declined coverage under the **Plan**. A **Late Applicant** is entitled to enroll during a **Special Enrollment Period** when the **Employee** marries or has a new **Child** as a result of marriage, birth, adoption or placement for adoption.

A **Late Applicant** entitled to enroll during a **Special Enrollment Period** must submit an **Enrollment Application** to **Unity** within 31 days of the date of the marriage, birth, adoption or placement for adoption. Coverage will be effective:

a. With respect to a marriage, the date of marriage or the first of the month following the date of marriage; or

b. With respect to a birth, adoption or placement for adoption, on the date of birth, adoption or placement for adoption.

6. Late Applicant/Special Enrollment for Loss of Other Coverage

An **Employee** who is not enrolled, but who is eligible for coverage under the terms of the **Group Plan**, or an **Employee's Dependent** who is not enrolled but who is eligible for

coverage under the terms of the **Group Plan**, may enroll for coverage during a **Special Enrollment Period** if all of the following apply:

a. The **Employee** or **Dependent** was covered under another group health plan or had **Health Insurance Benefit Plan** coverage at the time coverage was previously offered to the **Employee** or **Dependent**;

b. The **Employee** or **Dependent** stated in writing at the time **Unity** coverage was previously offered that coverage under another group health plan or **Health Insurance Benefit Plan** was the reason for declining enrollment under this **Plan**; and

c. The **Employee** or **Dependent** is currently covered under that prior group health plan or **Health Insurance Benefit Plan** or, under the terms of the **Group Plan**, the **Employee** or **Dependent** requests enrollment no later than 31 days after the date on which the coverage under paragraph "a." is exhausted or terminated. **Members** requesting coverage under this **Health Plan** more than 31 days after their other coverage ends should contact their employer to determine the length of their applicable **Waiting Period**.

d. The **Employee** or **Dependent** requests enrollment within 60 days of losing or being determined as eligible for Medicaid or a child health plan under title XXI of the Social Security Act. If **Your Enrollment Form** is received within the 60 day period, **Your** or **Your Dependent's** coverage will be effective on the first day of the month following receipt of the **Enrollment Form** by **Unity.**

B. Dependent Coverage

1. Eligibility

Except for full-time students, **Unity** considers a **Dependent's** "residence" to be the location in which he/she spends at least 9 months out of a 12-month period. Eligibility for coverage begins on:

a. The date the **Employee** is eligible for coverage, if the **Employee** has **Dependents** who may be covered on that date; or

b. Either the date of the **Employee's** marriage or the first day of the month following the date of the marriage (as determined by the employer) for any **Dependent** (spouse or stepchild) acquired through the marriage; or

c. The date of birth of the **Employee's** natural-born **Child**; or

d. The date a **Child** is placed in the **Employee's** home for adoption, or the date that a court issues a final order granting adoption or legal guardianship of the **Child** to the **Employee**, whichever occurs first; or

e. The date of change of status for a newly eligible **Dependent**; or

f. The date of birth of a **Child** born to an **Employee's** covered **Dependent Child** who is under the age of 18. The **Dependent** grandchild will be covered until the end of the month in which the **Dependent Child** turns age 18; or

g. For full-time students, the first day they become full-time students if:

i. The **Child** is a full-time student, and

ii. The **Child** was under 27 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. Armed Forces while the **Child** was attending, on a full-time basis, an institution of higher education, and applied to an institution of higher education as a full-time student within 12 months from the date the **Child** has fulfilled his or her active duty obligation.

Except for continuation and conversion coverage, an **Employee** may cover **Dependents** only if the **Employee** is covered.

2. Enrollment and Effective Date

a. Each **Dependent** must be enrolled on an **Enrollment Application Form** or electronically through **unityhealth.com**.

b. The **Effective Date** of coverage for each **Dependent** (other than a newborn or an adopted **Child**) is determined as follows:

i. If the **Enrollment Form** is received by **Unity** *before* the **Dependent's** eligibility date, the **Dependent** is covered on the date he/she is eligible.

ii. If the **Enrollment Form** is received *after* the **Dependent's** eligibility date, but within 31 days from the eligibility date, the **Dependent** is covered on the date approved by **Unity**.

iii. A **Dependent's Effective Date** may never be prior to the **Employee's Effective Date**.

iv. A new entrant may enroll within 31 days from the date he/she is notified of the opportunity to enroll and will be covered on the date **Unity** specifies. A **Dependent** is a new entrant:

(1) If he/she is a **Dependent** of an **Employee** who becomes part of the **Group** after the first enrollment period; or

(2) If a court orders him/her to be covered under the **Policy** and if he/she requests coverage after issuance of the court order; or

(3) He/she did not enroll during an enrollment period and, at that time, was covered by a **Health Insurance Benefit Plan**, loses that coverage, and requests coverage under this **Plan** within 31 days after the termination of the **Health Insurance Benefit Plan** coverage.

3. Late Applicant

If the **Subscriber** seeks to enroll a **Dependent** who is a **Late Applicant** who is not entitled to enroll during a **Special Enrollment Period**, then the **Dependent** will be enrolled in the **Plan** as of the date of application and subject to a 12-month **Waiting Period**. The **Effective Date** will be delayed by 12 months or that period of time up to an **Open Enrollment Period**, if any, whichever comes first, and coverage will be effective as of that date.

4. Newborn Effective Date of Coverage

The **Employee** has 60 days from the date of birth of a **Child** to apply for **Dependent** coverage effective on the newborn's birth date. The **Employee** may apply for **Dependent** coverage for a newborn up to one year after the newborn's birth date if the **Employee** pays all past **Premium** plus interest on such **Premium** at the rate of 5-1/2% per year.

5. Adopted Child Effective Date of Coverage

The **Employee** has 60 days from the date a **Child** is placed in the custody of the **Employee** or from the date a court issues a final order granting adoption of the **Child** by the **Employee**, whichever occurs first, to apply for **Dependent** coverage effective on the date of eligibility.

C. Changes to Enrollment Form

Changes to the original **Enrollment Form**, other than **Physician** changes, must be made by completing a new **Enrollment Form** or by submitting the change electronically by logging on to **unityhealth.com**.

D. Termination of Coverage

1. Coverage terminates for **Employees** and covered **Dependents** on the date that one of the following occurs:

a. The **Policy** terminates; or

b. A service is no longer a **Covered Service** under the **Policy**, except that termination then relates only to that **Covered Service**.

2. Coverage also terminates for **Employees** and covered **Dependents** for any of the following reasons:

a. The **Employee's** employment terminates; or

b. The **Employee** ceases to meet eligibility requirements or is no longer in a class of **Employees** that is eligible for coverage under the **Policy**; or

c. The **Member** requests voluntary **Disenrollment**; or

d. The **Employee** retires, unless the employer requests retiree coverage on the **Group Application Form** and **Unity** approves such request; or

e. The **Dependent** no longer qualifies as an eligible **Dependent**.

The termination date for these reasons will be at the end of the month in which the change occurs. **Unity** may backdate terminations and additions no more than 30 days from the date of the request.

E. Right to Continue Group Medical Coverage

1. The **Member** may have the right to continue coverage under the **Plan** if he/she ceases to meet eligibility requirements. A **Member** may elect this option if:

a. He/she is an **Employee** whose eligibility for **Group** coverage terminates (the option is not available if the **Employee** was fired for misconduct on the job); or

b. He/she is the former spouse of an **Employee**, and the marriage ends due to divorce or annulment while **Dependent** coverage is in effect; or

c. He/she is a surviving **Dependent** spouse or **Child** of an **Employee** who dies while **Dependent** coverage is in effect.

2. Wisconsin continuation law applies to employer **Groups** with fewer than 20 **Employees**. This option is available only if the **Member** has been covered under the **Plan** for at least 3 consecutive months. The maximum continuation period is 18 months. The employer must provide the **Member** with written notice of continuation rights within 5 days after the date the **Member's** eligibility for coverage terminates. The **Member** has 30 days from the date of the notice to elect the continuation option and pay the **Premium** due to the **Group**. The employer will tell the **Member** when and how much payment is due and will send payment to **Unity**. The **Member** must complete a new **Enrollment Form** if he/she is a former spouse or a surviving **Dependent** spouse or **Child**.

3. Federal continuation law is governed by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA applies to **Groups** with 20 or more **Employees.** The maximum continuation period is 18 consecutive months from the date the **Member** elects to continue coverage. This period of time is modified to:

a. 29 months if the **Member** (i) is disabled at the time **Group** coverage terminates due to cessation of employment or reduction of hours, or (ii) becomes disabled within the first 60 days thereafter, provided that the **Member** has been determined to be disabled for Social Security purposes and the **Member** provides **Unity** with notice of such determination within 60 days of the determination and before the end of the 18-month continuation period.

b. 36 months if a **Dependent** loses coverage due to (i) divorce or death of the **Employee**, or (ii) the **Employee** becomes eligible for **Medicare**, or (iii) if a **Child** of an enrolled **Employee** no longer meets the definition of "**Dependent**" under the **Policy**.

c. Special COBRA rights apply to **Subscribers** who have been terminated or experience a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These **Subscribers** are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) but only within a limited period of 60 days or less and only during the 6 months immediately after their group health plan coverage ended.

If **You** qualify for assistance under the Trade Act of 1974, contact **Your** employer promptly after qualifying for assistance or **You** will lose these special COBRA rights.

4. The continuation coverage period is measured from the exact date continuation coverage is elected or becomes effective to the same calendar date of the succeeding months. Coverage continues until:

a. The date the **Member** is covered under another similar group medical plan; or

b. The end of the last month for which **Premium** was paid by the **Member** when due; or

c. If the **Member** is the former spouse of an **Employee**, the date the **Employee** is no longer covered by the **Group Plan** or replacement group policy.

5. A **Child** born to a **Member** or placed for adoption with a **Member** is eligible for continuation coverage and may be enrolled in accordance with the provisions contained in the section entitled "Dependent Coverage."

F. Medical Conversion Privilege

1. If the **Member** does not elect continuation coverage, or if the **Member** elected continuation coverage and it terminates, or if the **Plan** terminates, a conversion policy may be available without medical underwriting. A **Member** qualifies for a conversion policy if he/she was covered under the **Group Plan** for at least 3 consecutive months and:

a. He/she is an **Employee** whose eligibility for **Group** coverage terminates (the option is not available if the **Employee** was fired for misconduct on the job); or

b. He/she is the former spouse of an **Employee** and the marriage ends due to divorce or annulment while **Dependent** coverage is in effect; or

c. He/she has been a covered **Dependent Child** but no longer meets the definition of "**Dependent**" under the **Policy**.

2. The employer is required to provide the **Member** with written notice of these rights within 5 days after the date the employer knows that the **Member's** eligibility for coverage will terminate.

3. The **Member** has 30 days after the date **Group** coverage terminates to apply for the conversion policy and pay the required **Premium** to **Unity**. The **Premium** must be paid in advance and monthly. **Members** may obtain application forms at **unityhealth.com** or by contacting **Unity** Customer Service. The conversion policy will be effective on the day after the **Group** coverage ends, provided the **Member** enrolls and pays the first **Premium** within 30 days after the date coverage terminates.

4. Benefits provided under the conversion policy may differ from the benefits provided under the **Group Plan**.

5. **Unity** may refuse to issue a conversion policy if **We** determine that the applicant has other similar coverage or if the applicant resides outside Wisconsin. The conversion policy will not be available if it would result in over-insurance or duplication of benefits. **Unity** will use the standards for over-insurance filed with the Wisconsin Office of the Commissioner of Insurance.

G. Disenrollment from the Plan

"**Disenrollment**" means that a **Member's** coverage under the **Plan** is revoked. Coverage is contingent upon the **Subscriber's** continued eligibility and timely payment of **Premium**. **Unity** may disenroll a **Member** only for the reasons listed below:

1. The **Member** and/or any **Dependents** have moved outside **Unity's Service Area**. This does not include full-time student **Dependents** who attend school outside the **Service Area** or **Dependent** children residing outside the **Service Area**. However, it must be noted that coverage for such **Dependents** while outside the **Service Area** is limited to **Emergency Services** and **Urgent Care Services**; or

2. Required **Premium** is not paid by the end of the grace period (31 days); or

3. The **Member** commits acts of physical or verbal abuse which pose a threat to **Providers** or **Unity** employees.

4. The **Member** allows a non-member to use the **Member's Identification Card** to obtain services; or

5. The **Member** has performed an act, practice or omission that constitutes fraud in applying for coverage and at least 30 days advance written notice has been provided to each **Member** who would be affected by the disenrollment; or

6. The **Member** demands access to a **Participating Primary Care Physician** but is unable to establish or maintain a satisfactory physician-patient relationship with that **Physician**. **Disenrollment** for this reason is permitted only if it can be demonstrated that **Unity**:

a. Provided the **Member** an opportunity to select another **Participating Primary Care Physician**;

b. Made a reasonable effort to assist in establishing a satisfactory physician-patient relationship; and

c. Properly communicated **Grievance** procedures to the **Member**.

Except in the case of non-payment of **Premium**, **Unity** will arrange to provide similar alternative medical coverage for a terminated **Member** until the **Member** finds his/her own coverage or until the next opportunity to change insurers, whichever occurs first.

H. Extension of Coverage Due to Total Disability

If **Unity** terminates coverage under this **Certificate** for any reason other than the employer's failure to pay required **Premiums** for all **Members** of the **Group**, and a **Member** is **Totally Disabled** on the date of termination, Unity will continue to provide benefits related to the disabling condition until the earliest of the following occurrences:

1. **Total Disability** terminates,

2. The end of the 12 consecutive months immediately following the termination of coverage,

3. The benefit period specified in the **Policy** ends,

4. The maximum benefit is paid, or

5. Similar coverage for the condition or conditions causing the **Total Disability** is provided under another group policy.

This extended coverage does not apply to dental or uncomplicated pregnancy expenses or to a condition other than the condition or conditions causing the **Total Disability**.

ARTICLE VII: COMPLAINT AND GRIEVANCE PROCEDURE

A. Resolving Complaints

If **You** have a **Complaint** relating to any aspect of **Unity**, **You** may contact a Customer Service Representative who will assist in resolving the matter informally. If the **Complaint** cannot be resolved to **Your** satisfaction, **You** may file a **Grievance**.

B. Definitions

"**Adverse Benefit Determination**" includes any of the following:

(a) The determination that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational, and the requested service or payment for the service is therefore denied, reduced or terminated.

(b) Any rescission of coverage, as provided in 45 CFR s. 147.136 (b) (2) (ii) (A) as amended, whether or not the rescission has an adverse effect on any particular benefit at that time.

(c) The denial of a request for a referral for out-of-network services when the insured requests health care services from a provider that does not participate in the insurer's provider network because the clinical expertise of the provider may be medically necessary for treatment of the insured's medical condition and that expertise is not available in the insurer's provider network.

"**Coverage denial determination**" has the meaning as defined in sec. 632.835(1)(ag), Wis. Stats., and includes, for individual insurance products, a policy reformation or change in premium charged based upon underwriting or claims information greater than 25% from the premium in effect during the period of contest-ability except to the extent the modification is due to the applicant's age or a rate increase applied by the insurer to all similar individual policy forms applied uniformly.

"**Grievance**" means any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an insured including any of the following:

(a) Provision of services.
(b) Determination to reform or rescind a policy.
(c) Determination of a diagnosis or level of service required for evidence-based treatment of **Autism Spectrum Disorders**.
(d) Claims practices.

"**Reconsideration Committee**" means Unity's grievance panel for the investigation of each written grievance.

C. Filing Grievances

1. Submit the signed **Grievance** and any supporting materials to the Reconsideration Committee at the following address:

UNITY HEALTH PLANS INSURANCE CORPORATION
ATTN: RECONSIDERATION COMMITTEE
840 Carolina Street
Sauk City, WI 53583-1374

Or, **You** may email **Your** grievance to- MemberAdvocates@Unityhealth.com or fax it to 608-644-2080.

Unity will acknowledge receipt of the **Grievance** within 5 business days of receiving it.

2. **Unity** will notify **You** of the time and place of the Reconsideration Committee meeting at least 7 calendar days in advance. **You**, or a person acting on **Your** behalf, have the right to appear before the Reconsideration Committee in person or by telephone to present written or oral information concerning the **Grievance**. **You** may also submit written questions to the persons responsible for making the determination that resulted in the denial or determination of benefits or a decision to disenroll **You**.

3. **Unity** will notify **You** of the disposition of the **Grievance** within 30 calendar days of receipt. If **We** are not able to resolve the **Grievance** within 30 calendar days, the time period may be extended an additional 30 calendar days. If an extension is required, **We** will notify **You** in writing:

a. Of the reasons for extension, and

b. When resolution may be expected.

4. The time periods set forth in paragraphs 1 through 3 do not apply in urgent situations. If a **Grievance** involves an urgent situation, **Unity** will treat it as an **Expedited Grievance** and will resolve it within 72 hours after receipt. An urgent situation is one which could result in serious or irreparable harm to **Your** health if the time periods provided by the regular **Grievance** procedure applied. **You** may request an **Expedited Grievance** by calling us at 800-362-3009, Prompt #6, emailing **Your** request to MemberAdvocates@Unityhealth.com, or faxing it to 608-644-2080.

5. **You** may review **Unity's** claim file without charge. Any new or additional evidence or rational considered, relied upon or generated by **Unity** in connection with the claim after the internal **Adverse Benefit Determination** will be provided to you at least 3 calendar days in advance of the Reconsideration Committee Meeting.

D. **Filing Complaints with the Office of the Commissioner of Insurance**

You may resolve a problem by taking the steps outlined above or by filing a **Complaint** with the Wisconsin Office of the Commissioner of Insurance (OCI). OCI is a state agency that enforces Wisconsin's insurance laws.

To file a complaint online or to print a complaint form:
OCI's Web Page: oci.wi.gov

Office of the Commissioner of Insurance
P. O. Box 7873
Madison, WI 53707-7873

1-800-236-8517 (Statewide) or 608-266-0103 (in Madison)

E. **External Review (Independent Review)**

You or **Your** authorized representative may also begin an external review at the same time as the internal appeals process if it is an urgent situation or you are in an ongoing course of treatment. You may submit information directly to Maximus, the external review company, at www.externalappeal.com. You may also submit information to Unity. We will then send this information to Maximus on your behalf.

You may appeal to an External Review if:

1. The determination of the **Reconsideration Committee** is an **Adverse Benefit Determination**; or

2. The determination of the **Reconsideration Committee** is a preexisting condition exclusion denial determination or a rescission of a certificate; or

3. The determination was made that the requested treatment was **Experimental or Investigative**.

You must request External Review:

a. Within 4 months of the date that **We** denied the **Grievance**, or

b. Within 4 months of **Your** receipt of **Our** denial letter, whichever is later. It will be assumed that **You** received **Our** denial letter within 3 days of the postmark date unless **You** can establish receipt on a different date.

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1. The External Review will have 5 days to review this material and request additional information. Any additional information provided by **You** or **Unity** shall also be provided to the other party to the review within one business day of receipt by the External Reviewer.

2. **We** will respond to any requests for additional information within 5 days or provide an explanation as to why more time is needed.

3. The External Review process shall not exceed 45 days from the date the request for independent review is received by the insurer in compliance with 45 CFR 147.136 (c) (2) (xii) as amended.

There are certain circumstances when **You** may be able to skip Unity's internal **Grievance** process and proceed directly to External Review. Those circumstances are as follows:

1. **We** agree to proceed directly to External Review; or

2. **We** did not comply with the requirements of **Our** internal appeals process, except for failures that do not cause prejudice or harm to you; or

3. **Your** situation requires **Expedited Review**.

If **Your** situation requires **Expedited Review**:

1. The External Reviewer will review this material and request additional information. Any additional information provided by **You** or **Unity** shall also be provided to the other party to the review within one business day.

2. Once the External Reviewer has all the necessary information, it will make a decision as expeditiously as the Member's health condition requires. This will not exceed 72 after receipt of the request for expedited review.

3. If the External Reviewer decision is not in writing, the External Reviewer must provide written confirmation of its decision within 48 hours after the date of the notice of the decision.

4. For individual in urgent care situation who are also in an ongoing course of treatment for that condition, this External Review decision will be provided in 24 hours.

5. Once the External Reviewer makes a final coverage determination, the final coverage determination is binding upon **Unity** and the **Member** except to the extent other remedies are available under state or federal law.

6. **Your** request for **Expedited Review** can be initiated by calling the toll free number 1-888-866-6205.

ARTICLE VIII: CONSENT TO RELEASE INFORMATION

If **Unity** requests, **You** must authorize any person or institution that has examined or treated **You** to furnish to **Unity** any and all information and records or copies of records relating to the examination or treatment provided to **You** if related to claims payment. **Unity** agrees that such information and records will be considered confidential to the extent required by law. **Unity** has the right to submit any and all records concerning health care services provided to **You** to appropriate medical review personnel. The cost of obtaining medical records is **Your** responsibility.

Unity also has the right to review any employment records, including but not limited to those maintained by **Your** employer, to make certain that the employer and **You** are entitled to coverage.

ARTICLE IX: GENERAL PROVISIONS

A. Advance Directives

If **You** are over age 18 and of sound mind, **You** may execute a living will or durable power of attorney for health care. These documents tell others what **Your** wishes are if **You** are physically or mentally unable to express **Your** wishes in the future. If **You** have an advance directive, give a copy to **Your Primary Care Physician**. **You** do not need to send the forms to **Unity**.

B. Case Management

Case Management is a program **Unity** offers to **Members** of this **Plan**. These services are provided by a staff of health care professionals. As part of **Case Management**, **Unity** reserves the right to direct treatment to the most appropriate and cost-effective option available.

C. Conformity with Statutes

Any provision which, on the **Policy Effective Date**, is in conflict with federal or Wisconsin law is amended to conform to the minimum requirements of those laws.

D. Continuity of Care

Unity will provide coverage to a **Member** for the services of a **Provider**, regardless of whether the **Provider** is a **Participating Provider** at the time the services are rendered, if **Unity** represented the **Provider** as a **Participating Provider** in marketing materials made available to the **Member** for the current **Contract Year** and if the following conditions apply:

1. If **Your** chosen **Primary Care Physician** leaves **Unity's Provider Network**, **You** may continue seeing that **Physician** through the end of the **Plan's Contract Year**.

2. If **You** are seeing a specialist who leaves **Unity's Provider Network**, **You** may continue seeing the specialist:

a. If **You** are pregnant and in **Your** 2nd or 3rd trimester, through the postpartum period.

b. For 90 days past the **Physician's** termination date with **Unity** or through the end of the course of treatment, whichever is shorter.

3. This provision does not apply if the **Physician** is terminated from **Unity's Provider Network** for misconduct or if the **Physician** is no longer practicing in **Unity's Service Area**.

E. Filing Claims from Out-of-Plan Providers

If **You** pay for services from a **Non-Participating Provider**, please submit the itemized bill to **Unity** within 90 days from the date the services were provided. Circumstances beyond **Your** control might make this time limit unreasonable. If so, **You** must file the **Claim** as soon as possible, and pursuant to sec. 631.81, Wis. Stats., **We** will still process **Your Claim** if **You** submit it within one year after the time required under this provision. A Member Claim Form is available at **unityhealth.com**.

If **You** are submitting **Claims** for which **You** have already paid, and **You** are seeking **Unity's** reimbursement, you must provide proof of payment. The bill or receipt from your provider must match the service that **You** are seeking **Unity's** reimbursement for.

Participating Providers will submit **Claims** on **Your** behalf.

F. Legal Action

You may not start legal action against **Unity** until the earlier of:

1. 60 days after **You** file notice of a claim and complete the **Grievance** process; or

2. The date **Unity** denies the claim and **You** complete the **Grievance** process.

Despite the above provisions, **You** may opt to start legal action under ERISA Sec. 502(a) before completing the **Complaint** or **Grievance** process. If **You** do so, a court may dismiss **Your** lawsuit because **You** failed to complete the **Complaint** or **Grievance** process.

You may not start legal action against **Unity** more than 3 years from the time written proof of loss was required to be filed. **You** must file written proof of loss within 90 days of the date of service. This means that any legal action must be started within 39 months of the first date of service on which the action is based.

G. Physical Examination

Unity, at its own expense, has the right and opportunity to examine any **Member** when and as often as may be reasonably necessary to determine his/her eligibility for claimed services or benefits under this **Plan**, including, without limitation, issues relating to subrogation and **COB**. By executing an application for coverage under the **Plan**, each **Member** is deemed to have waived any legal right he/she may have to refuse consent to such examination when performed or conducted for the purposes set forth above.

H. Physician and Hospital Reports

Physicians and **Hospitals** must give **Unity** reports to help **Us** determine **Plan Benefits** due to **You**. **You** agree to cooperate with **Unity** to either execute releases that authorize **Physicians**, **Hospitals** and other **Providers** or, to release all records to **Unity** that relate to services **You** receive. This is also a condition of **Unity** paying benefits. All information must be furnished to the extent **Unity** deems necessary in a particular situation and as allowed by pertinent statutes.

I. Proof of Coverage

It is **Your** responsibility to show **Your Unity Identification Card** each time **You** receive **Covered Services** from a **Provider**.

J. Right to Collect Needed Information

You must cooperate with **Unity** and, when asked, must assist **Unity** by:

1. Authorizing the release of medical information, including the names of all **Physicians** and **Providers** from whom **You** received medical attention; and

2. Providing information regarding the circumstances of **Your Injury** or **Illness**; and

3. Providing information about other insurance coverage and benefits.

Your failure to assist **Us** may result in the denial of claims.

K. Services Covered by Liability Insurance

Unity will not refuse to cover health care services that **You** receive for which there is coverage under the **Plan** on the basis that there may be coverage for the services under a liability insurance policy.

L. Sharing Information

You agree to permit **Unity, Physicians**, **Providers** and reviewers to share information about **Your** care to promote the orderly delivery of care. Sharing information also promotes **Unity's** quality assurance and cost control programs. When sharing information with others, **Unity** agrees to preserve **Confidential Matters** in accordance with state and federal law.

M. Subrogation and Reimbursement

Unity retains both the right of subrogation against a third party and the right of reimbursement from Members from any and all recoveries obtained by a Member arising out an injury for which Unity has provided benefitsThis means that whenever **Unity** provides services or other benefits to any **Member**, **Unity** shall, to the extent permitted by law, be subrogated to and be entitled to be reimbursed from all the **Member's** rights of recovery and all actual recoveries for, and to the extent of, any services or benefits received by the **Member** that the **Member** may have against any other party, person or corporation, including any claims made pursuant to uninsured or underinsured motorist coverage.

Any **Member** who receives services or benefits from **Unity**, and has any right of recovery against any third party, including a claim made pursuant to uninsured or underinsured motorist coverage, must, by or on behalf of **Unity,** execute and sign all documents as may be required, deliver the same to **Unity** or **Unity's** designee and perform whatever other acts, including an assignment of rights, that are necessary to secure **Unity's** rights. **Members** must do nothing to prejudice **Unity's** right of recovery. **Members** must promptly advise **Unity** in writing whenever a claim against another party is made on behalf of the **Member** and will further provide such additional information as is reasonably requested by **Unity** or **Unity's** designee.

Unity reserves the right to be provided notice of any claim against a third party. The **Member** agrees to cooperate in protecting **Unity's** interest and to provide necessary information to **Unity** or **Unity's** designee upon request. Paid claims represent the reasonable cash value of the services paid on a capitated basis. Reasonable cash value is determined by utilizing actuarial methodologies.

Unity acknowledges that its right of subrogation is subject to the **Member** being made whole as defined by Wisconsin law. If a dispute arises between **Unity** and any **Member** over the question of whether the **Member** has been made whole, **Unity** reserves the right to a judicial determination of the **Member's** recovery. **Unity** shall not be responsible for the payment of attorneys' fees or costs associated with a Member's recovery unless Unity has expressly agreed to the payment of such costs in writing.

N. Time Limit on Certain Defenses

If the **Health Questionnaire** or an **Employer's Certification of Group Health Plan Coverage** is required for enrollment in this **Plan**, **Unity** may investigate information provided by the **Member** in applying for coverage for 2 years after the original **Effective Date** of coverage. After this 2-year period expires, no misstatements may be used to void coverage or to deny a **Claim** that arises after the 2-year period expires. This time limit does not apply to fraudulent misstatements made in the application for coverage under this **Plan**. Any fraudulent statement or intentional misrepresentation of material fact may result in a denial of a claim and/or rescission of coverage.

O. Travel Distances

Unity has established criteria to ensure that **Members** do not have to travel excessive distances to obtain health care services. Please contact **Unity** Customer Service with questions regarding these criteria.

For help to translate or understand this, please call (800) 362-3310, TTY (608) 643-1421.

Spanish – Este aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Unity. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica u obtener ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al (800) 362-3310. TTY: (608) 643-1421.

Hmong – Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog cov kev pab kam them nqi kho mob los ntawm Unity. Saib cov caij nyoog ceeb hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam kom tsis pub dhau cov caij nyoog koj thiaj yuav tau txais kev pab kam them nqi kho mob los yog kev pab them tej nqi kho mob. Koj muaj cai tau cov ntshiab lus no thiab tau kev pab ua koj hom lus pub dawb rau koj. Hu rau (800) 362-3310. TTY: (608) 643-1421.

Chinese – 本通知含有重要的訊息。本通知包含了關于您通過Unity提交之申請或保險責任範圍的重要訊息。請留意本通知內的重要日期。您可能需要在若幹截止日期之前采取行動，以維持您的健康保險責任範圍或者費用補貼。您有權利免費獲得以您母語撰寫的本訊息和各種幫助。請致電 (800) 362-3310。聾啞人電話：(608) 643-1421。

German – Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags oder Ihres Krankenversicherungsschutz durch Unity. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu erhalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter (800) 362-3310. TTY: (608) 643-1421.

Arabic – يحوي هذا الاشعار معلومات هامة. يحوي هذا الاشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال Unity. ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكالي لك الحق في الحصول على المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل ب 362-3310 (800). 643-1421 (608) :TTY.

Russian – Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Unity. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону (800) 362-3310. TTY: (608) 643-1421.

Korean – 본 통지서에는 중요한 정보가 들어 있습니다. 본 통지서에는 귀하의 신청 또는 Unity를 통한 보험보장에 관한 중요한 정보가 들어 있습니다. 본 통지서에 나와있는 중요한 날짜를 찾아보십시오. 귀하는 귀하의 건강 보험보장을 유지하기 위해 특정 마감일까지 조치를 취해야 할 수도 있거나, 비용에 관한 도움이 필요할 수도 있습니다. 귀하는 귀하가 사용하는 언어로 이러한 정보와 도움을 무료로 받을 권리가 있습니다. (800) 362-3310번으로 전화하십시오. TTY: (608) 643-1421.

Vietnamese – Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Unity. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số (800) 362-3310. TTY: (608) 643-1421.

Pennsylvanian Dutch – Die Bekanntmaching gebt wichdichi Auskunft. Die Bekanntmaching gebt wichdichi Auskunft baut dei Application oder Coverage mit Unity. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du (800)362-3310 uffrufe.

Laotian – ແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ. ແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການສະໝັກຂໍ ຫຼື ການຈຸ້ມຄອງຂອງທ່ານ ໂດຍຜ່ານ Unity. ໃຫ້ເບິ່ງກຳນົດວັນທີ່ສຳຄັນຢູ່ໃນແຈ້ງການນີ້. ທ່ານອາດຈະຕ້ອງໄດ້ໃຊ້ເວລາດຳເນີນການຕາມກຳນົດເວລາທີ່ແນ່ນອນ ເພື່ອຮັກສາການຄຸ້ມຄອງຂອງທ່ານ ຫຼື ການຊ່ວຍເຫຼືອທີ່ມີຄ່າໃຊ້ຈ່າຍ. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນຂ່າວສານ ແລະ ການຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ. ໃຫ້ໂທຫາເບີ (800) 362-3310. TTY: (608) 643-1421.

French – Cet avis contient des informations importantes. Cet avis contient des informations importantes concernant votre demande ou sur la prise en charge par Unity. Rechercher les dates importantes sur le présent avis. Il se peut qu'une action de votre part soit nécessaire avant une certaine date afin de conserver votre couverture santé ou votre aide sur les frais. Vous avez le droit d'obtenir gratuitement ces informations et une assistance dans votre langue. Appelez le (800) 362-3310. TTY: (608) 643-1421.

Polish – To zawiadomienie zawiera ważne informacje. To zawiadomienie zawiera ważne informacje dotyczące Państwa wniosku lub zakresu ubezpieczenia w Unity. Proszę zwrócić uwagę na ważne daty podane w zawiadomieniu. Mogą to być terminy dokonania określonych czynności koniecznych do zachowania ubezpieczenia zdrowotnego lub uzyskania pomocy związanej z kosztami. Mają Państwo prawo do otrzymania tej informacji oraz uzyskania pomocy bezpłatnie w swoim języku. Proszę dzwonić pod numer: (800) 362-3310. TTY: (608) 643-1421.

Hindi – इस नोटिस में महत्वपूर्ण जानकारी है। इस नोटिस में आपके आवेदन या Unity के माध्यम से बीमे के कवरेज बारे में महत्वपूर्ण जानकारी है। इस नोटिस में मुख्य तारीखें देखें। अपना स्वास्थ्य बीमा बनाए रखने या कीमत चुकाकर सहायता प्राप्त करने के लिए आपको कुछ निश्चित समयसीमा तक कार्रवाई करने की ज़रूरत हो सकती है। आपको कोई कीमत चुकाए बिना यह जानकारी और सहायता अपनी भाषा में प्राप्त करने का अधिकार है। कॉल करें (800) 362-3310। TTY: (608) 643-1421.

Albanian – Ky njoftim përmban informacion të rëndësishëm. Ky njoftim përmban informacion të rëndësishëm për aplikimin ose mbulimin tuaj nëpërmjet Unity. Kontrolloni për data të rëndësishme në këtë njoftim. Mund t'ju duhet të ndërmerrni veprim brenda afatave të caktuara për të mbajtur mbulimin tuaj shëndetësor ose për ndihmën me koston. Keni të drejtë ta merrni këtë informacion dhe ndihmë falas në gjuhën tuaj. Telefononi numrin (800) 362-3310. TTY: (608) 643-1421.

Tagalog – Ang Abisong ito ay may Importanteng Impormasyon. Ang abisong ito ay may importanteng impormasyon tungkol sa aplikasyon o proteksiyon mo sa pamamagitan ng Unity. Hanapin ang mga pangunahing petsa na nasa abisong ito. Maaaring kailangan mong kumilos bago sumapit ang ilang takdang araw para mapanatili ang proteksiyon ng kalusugan mo o para makatulong sa mga gastusin. Karapatan mong makuha ang impormasyon na ito na nasa wika mo nang walang gastos. Tumawag sa numerong (800) 362-3310. TTY: (608) 643-1421.

UH01647 (0816)

Unity Health Insurance complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, sexual orientation or health status.

Unity Health Insurance –

- Provides free aids and services to people with disabilities to communicate effectively with us, such as –
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as –
  - Qualified interpreter
  - Information written in other languages

If you need these services, contact Unity Customer Service at (800) 362-3310.

If you believe that Unity Health Insurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex you can file a grievance with –

Kristie Meier, Compliance Officer; 840 Carolina St.; Sauk City, WI 53583
Phone: (800) 362-3310; TTY number: (608) 643-1421; Fax: (608) 644-2080
Email: memberadvocates@unityhealth.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Kristie Meier, Compliance Officer, is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019; (800) 537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

Unity Health Insurance
Affiliated with UW Health

FINAL RATES
ACCEPTANCE FORM

The final rates offered to: **INDEPENDENCE SCHOOL DISTRICT**
by Unity Health Plans Insurance Corporation, effective **7/1/2017** are:

	HMO1-1	PPO1-1
Single	$773.23	$903.05
Family	$1,739.77	$2,031.86
Medicare Single	$618.58	$722.44
Medicare Family	$1,237.17	$1,444.88
Medicare Split	$1,391.81	$1,625.49
We accept the following plan(s):	[X]	[X]

SBC Tracking IDs:	ZZRGE4ZSBC	USF5BQMSBC
SOB Tracking IDs:	ZZRGE4ZSOB	USF5BQMSOB

Please review the above final adjusted rates. If these rates are acceptable to you, please execute the Acceptance Certification provided below. If your group has any changes within 60 days of the effective date that Unity determines will affect the rates listed above, Unity reserves the right to adjust the listed rates.

Please keep a copy of this certification form for your records, and return the signed original to your Sales Representative or Agent.

INDEPENDENCE SCHOOL DISTRICT understands that Unity Health Plans Insurance Corporation, in its sole discretion, may provide summary health information for our use. I request, on behalf of INDEPENDENCE SCHOOL DISTRICT, that INDEPENDENCE SCHOOL DISTRICT receives this summary health information for the purposes of 1) modifying, amending, or terminating the group health plan; or, 2) obtaining premium bids from health plans for providing health insurance coverage under the group health plan. I certify that I am authorized to sign on behalf of INDEPENDENCE SCHOOL DISTRICT.

Acceptance Certification

As an authorized representative of this Employer, I have reviewed the above, and the notice form, and accept the quoted rates on behalf of INDEPENDENCE SCHOOL DISTRICT. I further attest and certify that all the statements included herein are true and correct to the best of my knowledge.

INDEPENDENCE SCHOOL DISTRICT

Independence School District — 6/8/17
Printed Name of Group Representative — **Date**

Barry A. Schmidt
Signature of Group Representative — **Signature of Sales Representative or Agent**

Please send the completed form to:
Christopher Sans Crainte
Unity Health Insurance
840 Carolina Street
Sauk City, WI 53583
Fax Number 608-836-0092

Unity Health Insurance
Affiliated with UW Health

Independence School District
9099851 - Proposal - PPO HSA

Coverage Period: 7/1/2017 - 6/30/2018
Coverage for: Single/Family| **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **https://unityhealth.com/apps/CertLookup**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **www.unityhealth.com** or call 1-800-362-3310 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In Network: **$1,750** Single/**$3,500** Family per Benefit Year Out of Network: **$3,500** Single/**$7,000** Family per Benefit Year	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In Network: **$3,500** Single/**$7,000** Family per Benefit Year Out of Network: **$4,000** Single/**$8,000** Family per Benefit Year	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain prior authorization, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.unityhealth.com/findadoctor or call 1-800-362-3310 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after deductible	40% coinsurance after deductible	Charges for e-Visits will apply to your deductible/coinsurance.
	Specialist visit	20% coinsurance after deductible	40% coinsurance after deductible	----------none----------
	Other practitioner office visit	Chiro/Adult Vision: 20% coinsurance after deductible	Chiro/Adult Vision: 40% coinsurance after deductible.	Benefits are not available for care that is Maintenance and Supportive Care or Long-term Therapy. Glasses/contacts for Adult Routine Vision are not covered.
	Preventive care/screening/ immunization	No charge	40% coinsurance after deductible	Coverage is limited to preventive services as defined by the Affordable Care Act. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	----------none----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	----------none----------
If you need drugs to treat your illness or condition More information about **prescription drug**	Preferred Generics | Tier 1	20% coinsurance after deductible	20% coinsurance after deductible	----------none----------
	Preferred Brands | Tier 2	20% coinsurance after deductible	20% coinsurance after deductible	
	Non-Preferred Brands & Generics | Tier 3	20% coinsurance after deductible	20% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
coverage is available at www.unityhealth.com/drugformulary	Specialty drugs | Tier 4	20% coinsurance after deductible for Preferred 20% coinsurance after deductible for Non-preferred	20% coinsurance after deductible for Preferred 20% coinsurance after deductible for Non-preferred	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	Prior authorization may be required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after deductible	----------none----------
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	----------none----------
	Urgent care	20% coinsurance after deductible	40% coinsurance after deductible	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Benefits are not available for care that is Maintenance and Supportive Care or Long-term therapy.
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
If you are pregnant	Office visits	20% coinsurance after deductible	40% coinsurance after deductible	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	Prior authorization is required for inpatient services. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Coverage is limited to 60 visits per Benefit Year. Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Coverage for Physical, Speech and Occupational therapy is limited to a combined total of 40 visits per Benefit Year. Cardiac Rehab is limited to 36 visits per event.
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Coverage for Physical, Speech and Occupational therapy is limited to a combined total of 40 visits per Benefit Year. Prior Authorization may be required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Coverage limited to 90 days per confinement. Prior Authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
	Durable medical equipment	No charge after deductible	20% coinsurance after deductible	Coverage for -- Foot Orthotics: Limited to one pair per Benefit Year. Hearing Aids: Limited to one per ear every 36 months. To obtain the list of covered hearing aid models log onto unityhealth.com/hearing aids or contact Customer Service. Prior authorization may be required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information. Purchase or rental of DME with a per unit cost of $500 or more must be Prior Authorized.
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance after deductible	Limited to one exam per Benefit Year.
	Children's glasses	Not Covered	Not Covered	----------none----------
	Children's dental check-up	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

• Dental care (Adult)	• Private-duty nursing	

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic care	• Hearing aids	• Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or for assistance, contact: Office of the Commissioner of Insurance, Complaints Department, PO Box 7873, Madison, WI 53707-7873, or if coverage is under a group health plan the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Does this Plan Provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-362-3310 or 1-800-877-8973 (TTY).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-362-3310 or 1-800-877-8973 (TTY)
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-362-3310 or 1-800-877-8973 (TTY)
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-362-3310 or 1-800-877-8973 (TTY)

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,750**
Specialist copayment	**Deductible**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$0
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$3,510**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,750**
Specialist copayment	**Deductible**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,800
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,900**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,750**
Specialist copayment	**Deductible**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,800
Copayments	$0
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,840**

For help to translate or understand this, please call (800) 362-3310, TTY / TDD: 711 / (800) 877-8973.

Spanish – Este aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Unity. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica u obtener ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Hmong – Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog cov kev pab kam them nqi kho mob los ntawm Unity. Saib cov caij nyoog ceeb hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam kom tsis pub dhau cov caij nyoog koj thiaj yuav tau txais kev pab kam them nqi kho mob los yog kev pab them tej nqi kho mob. Koj muaj cai tau cov ntshiab lus no thiab tau kev pab ua koj hom lus pub dawb rau koj. Hu rau (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Chinese – 本通知含有重要的訊息。本通知包含了關于您通過Unity提交之申請或保險責任範圍的重要訊息。請留意本通知內的重要日期。您可能需要在若幹截止日期之前采取行動，以維持您的健康保險責任範圍或者費用補貼。您有權利免費獲得以您母語撰寫的本訊息和各種幫助。請致電 (800) 362-3310。聾啞人電話：711 / (800) 877-8973.。

German – Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags oder Ihres Krankenversicherungsschutz durch Unity. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu erhalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Arabic – يحوي هذا الاشعار معلومات هامة. يحوي هذا الاشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال Unity. ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. لك الحق في الحصول على المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل ب (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Russian – Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Unity. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Korean – 본 통지서에는 중요한 정보가 들어 있습니다. 본 통지서에는 귀하의 신청 또는 Unity를 통한 보험보장에 관한 중요한 정보가 들어 있습니다. 본 통지서에 나와있는 중요한 날짜를 찾아보십시오. 귀하는 귀하의 건강 보험보장을 유지하기 위해 특정 마감일까지 조치를 취해야 할 수도 있거나, 비용에 관한 도움이 필요할 수도 있습니다. 귀하는 귀하가 사용하는 언어로 이러한 정보와 도움을 무료로 받을 권리가 있습니다. (800) 362-3310 번으로 전화하십시오. TTY / TDD: 711 / (800) 877-8973.

Vietnamese – Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Unity. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Pennsylvanian Dutch – Die Bekanntmaching gebt wichdichi Auskunft. Die Bekanntmaching gebt wichdichi Auskunft baut dei Application oder Coverage mit Unity. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du (800) 362-3310 uffrufe. TTY / TDD: 711 / (800) 877-8973.

Laotian – ແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ. ແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການສະໝັກຂໍ ຫຼື ການຄຸ້ມຄອງຂອງທ່ານ ໂດຍຜ່ານ Unity. ໃຫ້ເບິ່ງກຳນົດວັນທີສຳຄັນຢູ່ໃນແຈ້ງການນີ້. ທ່ານອາດຈະຕ້ອງໄດ້ໃຊ້ເວລາດຳເນີນການຕາມກຳນົດເວລາທີ່ແນ່ນອນ ເພື່ອຮັກສາການຄຸ້ມຄອງຂອງທ່ານ ຫຼື ການຊ່ວຍເຫຼືອທີ່ມີຄ່າໃຊ້ຈ່າຍ. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນຂ່າວສານ ແລະ ການຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ. ໃຫ້ໂທຫາເບີ (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

French – Cet avis contient des informations importantes. Cet avis contient des informations importantes concernant votre demande ou sur la prise en charge par Unity. Rechercher les dates importantes sur le présent avis. Il se peut qu'une action de votre part soit nécessaire avant une certaine date afin de conserver votre couverture santé ou votre aide sur les frais. Vous avez le droit d'obtenir gratuitement ces informations et une assistance dans votre langue. Appelez le (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Polish – To zawiadomienie zawiera ważne informacje. To zawiadomienie zawiera ważne informacje dotyczące Państwa wniosku lub zakresu ubezpieczenia w Unity. Proszę zwrócić uwagę na ważne daty podane w zawiadomieniu. Mogą to być terminy dokonania określonych czynności koniecznych do zachowania ubezpieczenia zdrowotnego lub uzyskania pomocy związanej z kosztami. Mają Państwo prawo do otrzymania tej informacji oraz uzyskania pomocy bezpłatnie w swoim języku. Proszę dzwonić pod numer: (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Hindi – इस नोटिस में महत्वपूर्ण जानकारी है। इस नोटिस में आपके आवेदन या Unity के माध्यम से बीमे के कवरेज बारे में महत्वपूर्ण जानकारी है। इस नोटिस में मुख्य तारीखें देखें। अपना स्वास्थ्य बीमा बनाए रखने या कीमत चुकाकर सहायता प्राप्त करने के लिए आपको कुछ निश्चित समयसीमा तक कार्रवाई करने की ज़रूरत हो सकती है। आपको कोई कीमत चुकाए बिना यह जानकारी और सहायता अपनी भाषा मे प्राप्त करने का अधिकार है। कॉल करें (800) 362-3310। TTY / TDD: 711 / (800) 877-8973.

Albanian – Ky njoftim përmban informacion të rëndësishëm. Ky njoftim përmban informacion të rëndësishëm për aplikimin ose mbulimin tuaj nëpërmjet Unity. Kontrolloni për data të rëndësishme në këtë njoftim. Mund t'ju duhet të ndërmerrni veprim brenda afatave të caktuara për të mbajtur mbulimin tuaj shëndetësor ose për ndihmën me koston. Keni të drejtë ta merrni këtë informacion dhe ndihmë falas në gjuhën tuaj. Telefononi numrin (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Tagalog – Ang Abisong ito ay may Importanteng Impormasyon. Ang abisong ito ay may importanteng impormasyon tungkol sa aplikasyon o proteksiyon mo sa pamamagitan ng Unity. Hanapin ang mga pangunahing petsa na nasa abisong ito. Maaaring kailangan mong kumilos bago sumapit ang ilang takdang araw para mapanatili ang proteksiyon ng kalusugan mo o para makatulong sa mga gastusin. Karapatan mong makuha ang impormasyon na ito na nasa wika mo nang walang gastos. Tumawag sa numerong (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Unity Health Insurance complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, sexual orientation or health status.

Unity Health Insurance –

- Provides free aids and services to people with disabilities to communicate effectively with us, such as –
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as –
  - Qualified interpreter
  - Information written in other languages

If you need these services, contact Unity Customer Service at (800) 362-3310.

If you believe that Unity Health Insurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex you can file a grievance with –

Kristie Meier, Compliance Officer; 840 Carolina St.; Sauk City, WI 53583
Phone: (800) 362-3310; TTY / TDD: 711 or toll free (800) 877-8973; Fax: (608) 644-2080
Email: memberadvocates@unityhealth.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Kristie Meier, Compliance Officer, is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019; (800) 537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

Unity Health Insurance
Affiliated with UW Health

Independence School District
9099820 - Proposal - HMO HSA

Coverage Period: 7/1/2017 - 6/30/2018
Coverage for: Single/Family| **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **https://unityhealth.com/apps/CertLookup**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **www.unityhealth.com** or call 1-800-362-3310 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,750** Single/**$3,500** Family per Benefit Year	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$3,500** Single/**$7,000** Family per Benefit Year	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain prior authorization, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.unityhealth.com/findadoctor or call 1-800-362-3310 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	In-Network providers: No. Out-of-Network providers: Yes, written referral is required.	In-Network: You can see the specialist you choose without a referral. Out-of-Network: This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after deductible	Not Covered	Charges for e-Visits will apply to your deductible/coinsurance.
	Specialist visit	20% coinsurance after deductible	Not Covered	----------none----------
	Other practitioner office visit	Chiro/Adult Vision: 20% coinsurance after deductible	Not Covered	Benefits are not available for care that is Maintenance and Supportive Care or Long-term Therapy. Adult eyewear coverage is limited to $150 per Benefit Year.
	Preventive care/screening/ immunization	No charge	Not Covered	Coverage is limited to preventive services as defined by the Affordable Care Act. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	Not Covered	----------none----------
	Imaging (CT/PET scans, MRIs)	MRI/MRA: 20% coinsurance after deductible CT: 20% coinsurance after deductible PET: 20% coinsurance after deductible	Not Covered	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.unityhealth.com/drugformulary	Preferred Generics | Tier 1	20% coinsurance after deductible	20% coinsurance after deductible	----------none----------
	Preferred Brands | Tier 2	20% coinsurance after deductible	20% coinsurance after deductible	
	Non-Preferred Brands & Generics | Tier 3	20% coinsurance after deductible	20% coinsurance after deductible	
	Specialty drugs | Tier 4	20% coinsurance after deductible for Preferred 20% coinsurance after deductible for Non-preferred	20% coinsurance after deductible for Preferred 20% coinsurance after deductible for Non-preferred	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not Covered	Prior authorization may be required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after deductible	----------none----------
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	----------none----------
	Urgent care	20% coinsurance after deductible	20% coinsurance after deductible	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not Covered	Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	Not Covered	Benefits are not available for care that is Maintenance and Supportive Care or Long-term therapy.
	Inpatient services	20% coinsurance after deductible	Not Covered	Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
If you are pregnant	Office visits	20% coinsurance after deductible	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance after deductible	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
	Childbirth/delivery facility services	20% coinsurance after deductible	Not Covered	Prior authorization is required for inpatient services. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	Not Covered	Coverage is limited to 60 visits per Benefit Year. Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Rehabilitation services	20% coinsurance after deductible	Not Covered	Coverage for Physical, Speech and Occupational therapy is limited to a combined total of 40 visits per Benefit Year. Cardiac Rehab is limited to 36 visits per event.
	Habilitation services	20% coinsurance after deductible	Not Covered	Coverage for Physical, Speech and Occupational therapy is limited to a combined total of 40 visits per Benefit Year. Prior Authorization may be required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Skilled nursing care	20% coinsurance after deductible	Not Covered	Coverage limited to 90 days per confinement. Prior Authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance after deductible	Not Covered	Coverage for -- Foot Orthotics: Limited to one pair per Benefit Year. Hearing Aids: Limited to one per ear every 36 months. To obtain the list of covered hearing aid models log onto unityhealth.com/hearing aids or contact Customer Service. Prior authorization may be required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Hospice services	20% coinsurance after deductible	Not Covered	Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
If your child needs dental or eye care	Children's eye exam	No charge	Not Covered	Limited to one exam per Benefit Year.
	Children's glasses	20% coinsurance after deductible	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or for assistance, contact: Office of the Commissioner of Insurance, Complaints Department, PO Box 7873, Madison, WI 53707-7873, or if coverage is under a group health plan the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Does this Plan Provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-362-3310 or 1-800-877-8973 (TTY).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-362-3310 or 1-800-877-8973 (TTY)
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-362-3310 or 1-800-877-8973 (TTY)
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-362-3310 or 1-800-877-8973 (TTY)

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,750
Specialist copayment	Deductible
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$0
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$3,510**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,750
Specialist copayment	Deductible
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,800
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,750
Specialist copayment	Deductible
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,800
Copayments	$0
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,840**

For help to translate or understand this, please call (800) 362-3310, TTY / TDD: 711 / (800) 877-8973.

Spanish – Este aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Unity. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica u obtener ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Hmong – Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog cov kev pab kam them nqi kho mob los ntawm Unity. Saib cov caij nyoog ceeb hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam kom tsis pub dhau cov caij nyoog koj thiaj yuav tau txais kev pab kam them nqi kho mob los yog kev pab them tej nqi kho mob. Koj muaj cai tau cov ntshiab lus no thiab tau kev pab ua koj hom lus pub dawb rau koj. Hu rau (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Chinese – 本通知含有重要的訊息。本通知包含了關于您通過Unity提交之申請或保險責任範圍的重要訊息。請留意本通知內的重要日期。您可能需要在若幹截止日期之前采取行動，以維持您的健康保險責任範圍或者費用補貼。您有權利免費獲得以您母語撰寫的本訊息和各種幫助。請致電 (800) 362-3310。聾啞人電話：711 / (800) 877-8973.。

German – Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags oder Ihres Krankenversicherungsschutz durch Unity. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu erhalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Arabic – يحوي هذا الاشعار معلومات هامة. يحوي هذا الاشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال Unity. ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. لك الحق في الحصول على المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل ب (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Russian – Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Unity. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Korean – 본 통지서에는 중요한 정보가 들어 있습니다. 본 통지서에는 귀하의 신청 또는 Unity를 통한 보험보장에 관한 중요한 정보가 들어 있습니다. 본 통지서에 나와있는 중요한 날짜를 찾아보십시오. 귀하는 귀하의 건강 보험보장을 유지하기 위해 특정 마감일까지 조치를 취해야 할 수도 있거나, 비용에 관한 도움이 필요할 수도 있습니다. 귀하는 귀하가 사용하는 언어로 이러한 정보와 도움을 무료로 받을 권리가 있습니다. (800) 362-3310 번으로 전화하십시오. TTY / TDD: 711 / (800) 877-8973.

Vietnamese – Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Unity. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Pennsylvanian Dutch – Die Bekanntmaching gebt wichdichi Auskunft. Die Bekanntmaching gebt wichdichi Auskunft baut dei Application oder Coverage mit Unity. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du (800) 362-3310 uffrufe. TTY / TDD: 711 / (800) 877-8973.

Laotian – ແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ. ແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການສະໝັກຂໍ ຫຼື ການຄຸ້ມຄອງຂອງທ່ານ ໂດຍຜ່ານ Unity. ໃຫ້ເບິ່ງກຳນົດວັນທີສຳຄັນຢູ່ໃນແຈ້ງການນີ້. ທ່ານອາດຈະຕ້ອງໄດ້ໃຊ້ເວລາດຳເນີນການຕາມກຳນົດເວລາທີ່ແນ່ນອນ ເພື່ອຮັກສາການຄຸ້ມຄອງຂອງທ່ານ ຫຼື ການຊ່ວຍເຫຼືອທີ່ມີຄ່າໃຊ້ຈ່າຍ. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນຂ່າວສານ ແລະ ການຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ. ໃຫ້ໂທຫາເບີ (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

French – Cet avis contient des informations importantes. Cet avis contient des informations importantes concernant votre demande ou sur la prise en charge par Unity. Rechercher les dates importantes sur le présent avis. Il se peut qu'une action de votre part soit nécessaire avant une certaine date afin de conserver votre couverture santé ou votre aide sur les frais. Vous avez le droit d'obtenir gratuitement ces informations et une assistance dans votre langue. Appelez le (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Polish – To zawiadomienie zawiera ważne informacje. To zawiadomienie zawiera ważne informacje dotyczące Państwa wniosku lub zakresu ubezpieczenia w Unity. Proszę zwrócić uwagę na ważne daty podane w zawiadomieniu. Mogą to być terminy dokonania określonych czynności koniecznych do zachowania ubezpieczenia zdrowotnego lub uzyskania pomocy związanej z kosztami. Mają Państwo prawo do otrzymania tej informacji oraz uzyskania pomocy bezpłatnie w swoim języku. Proszę dzwonić pod numer: (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Hindi – इस नोटिस में महत्वपूर्ण जानकारी है। इस नोटिस में आपके आवेदन या Unity के माध्यम से बीमे के कवरेज बारे में महत्वपूर्ण जानकारी है। इस नोटिस में मुख्य तारीखें देखें। अपना स्वास्थ्य बीमा बनाए रखने या कीमत चुकाकर सहायता प्राप्त करने के लिए आपको कुछ निश्चित समयसीमा तक कार्रवाई करने की ज़रूरत हो सकती है। आपको कोई कीमत चुकाए बिना यह जानकारी और सहायता अपनी भाषा मे प्राप्त करने का अधिकार है। कॉल करें (800) 362-3310। TTY / TDD: 711 / (800) 877-8973.

Albanian – Ky njoftim përmban informacion të rëndësishëm. Ky njoftim përmban informacion të rëndësishëm për aplikimin ose mbulimin tuaj nëpërmjet Unity. Kontrolloni për data të rëndësishme në këtë njoftim. Mund t'ju duhet të ndërmerrni veprim brenda afatave të caktuara për të mbajtur mbulimin tuaj shëndetësor ose për ndihmën me koston. Keni të drejtë ta merrni këtë informacion dhe ndihmë falas në gjuhën tuaj. Telefononi numrin (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Tagalog – Ang Abisong ito ay may Importanteng Impormasyon. Ang abisong ito ay may importanteng impormasyon tungkol sa aplikasyon o proteksiyon mo sa pamamagitan ng Unity. Hanapin ang mga pangunahing petsa na nasa abisong ito. Maaaring kailangan mong kumilos bago sumapit ang ilang takdang araw para mapanatili ang proteksiyon ng kalusugan mo o para makatulong sa mga gastusin. Karapatan mong makuha ang impormasyon na ito na nasa wika mo nang walang gastos. Tumawag sa numerong (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Unity Health Insurance complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, sexual orientation or health status.

Unity Health Insurance –

- Provides free aids and services to people with disabilities to communicate effectively with us, such as –
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as –
  - Qualified interpreter
  - Information written in other languages

If you need these services, contact Unity Customer Service at (800) 362-3310.

If you believe that Unity Health Insurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex you can file a grievance with –

Kristie Meier, Compliance Officer; 840 Carolina St.; Sauk City, WI 53583
Phone: (800) 362-3310; TTY / TDD: 711 or toll free (800) 877-8973; Fax: (608) 644-2080
Email: memberadvocates@unityhealth.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Kristie Meier, Compliance Officer, is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019; (800) 537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html.