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://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/** or call (800) 279-1301 or TTY 711. 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 https://www.dol.gov/ebsa/healthreform or https://www.healthcare.gov/sbc-glossary or call (800) 279-1301 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
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 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?	$7150 individual / $14300 family. Included in the out-of-pocket limit is a deductible and coinsurance limit, which for covered services is $0 individual / $0 family.	The out-of-pocket limit is the most you could pay in a year for covered services. The deductible and coinsurance limit does not include copayments. Once the deductible and coinsurance limit is met, the plan pays 100% of allowed amounts, not including copayments; the members pay copayments until they reach the total out-of-pocket limit. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balanced-billing charges, 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 http://www.deancare.com/find-a-doc/ or call 1-800-279-1301 or TTY 711 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 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
		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 copay/visit	Not covered	No coverage for Chiropractic maintenance or long-term therapy.
	Specialist visit	$20 copay/visit	Not covered	Infertility services are covered at 50% of $4,000 life time maximum.
	Preventive care/screening/ immunization	$0 copay/visit	Not covered	Services under the ACA guidelines will be covered as preventive. Services may have a limit on number of visits and/or specific age requirements. For additional information please see the Preventive Services section in your Member Certificate. 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)	0% coinsurance after deductible	Not covered	None
	Imaging (CT/PET scans, MRIs)	PET: 0% coinsurance after deductible CT/MRI: $0 copay/visit	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.deancare.com/pharmacy	Generic drugs (Tier 1)	$6 copay / prescription (retail)	Not covered (retail and mail order)	For mail order maintenance prescriptions, a 90-day supply (Tiers 1 & 2) for 2 copays; 90-day supply (Tier 3) for 3 copays.
	Preferred brand drugs (Tier 2)	$20 copay / prescription (retail)	Not covered (retail and mail order)	
	Non-preferred brand drugs (Tier 3)	$30 copay / prescription (retail)	Not covered (retail and mail order)	
	Specialty drugs	50% coinsurance for infertility drugs/prescription	Not covered (retail and mail order)	Tobacco cessation products will be covered with a $0 copay if member enrolls in the Quit for Life program. Failure to enroll in Quit for

* For more information about limitations and exceptions, see the plan or policy document at https://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		(retail)		Life will result in not covered Tobacco cessation products.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	0% coinsurance after deductible	Not covered	
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Initial emergency services are covered with out-of-network providers. Copay is waived if admitted for observation or inpatient.
	Emergency medical transportation	0% coinsurance after deductible	0% coinsurance after deductible	None
	Urgent care	$20 copay/visit	$20 copay/visit	Initial urgent care services are covered with out-of-network providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	0% coinsurance after deductible	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 copay/visit	Not covered	None
	Inpatient services	$0 copay/admission	Not covered	None
If you are pregnant	Office visits	$20 copay/visit	Not covered	Home or intentional out of hospital deliveries are not covered. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services	0% coinsurance after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	Not covered	60 visits/contract period.
	Rehabilitation services	0% coinsurance after deductible	Not covered	Rehabilitation care - 90 days/contract period PT/OT/ST - 60 visits/contract period Services for custodial care are a policy exclusion.

* For more information about limitations and exceptions, see the plan or policy document at https://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	0% coinsurance after deductible	Not covered	Habilitative therapies - 60 visits/contract period. Services for custodial care are a policy exclusion.
	Skilled nursing care	0% coinsurance after deductible	Not covered	30 days/confinement.
	Durable medical equipment	0% coinsurance after deductible	Not covered	None
	Hospice services	0% coinsurance after deductible	Not covered	None
If your child needs dental or eye care	Children's eye exam	$20 copay/visit	Not covered	None
	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 Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic services including surgery
- Dental care (Adult)
- Glasses
- Long-term care
- Non-emergency care when travelling outside the U.S.
- Private-duty nursing
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery after written approval and completion of Weight Management program.
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care
- Weight Loss Programs as part of our Comprehensive Weight Management Program

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform. Other coverage

* For more information about limitations and exceptions, see the plan or policy document at https://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/.

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 assistance, contact: Wisconsin Office of the Commissioner of Insurance at (800) 236-8517 or http://oci.wi.gov/ or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform.

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 plan meet the Minimum Value Standards? **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: (800) 279-1301 or TTY 711.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa: (800) 279-1301 or TTY 711.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码: (800) 279-1301 or TTY 711.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne': (800) 279-1301 or TTY 711.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at https://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/.

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	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$80**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$620**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)s*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$40**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Assistance – General Taglines

Dean Health Plan is required by federal law to provide the following information.

If you, or someone you're helping, have questions about Dean Health Plan, you have the right to get help and information in your preferred language at no cost. To talk with an interpreter, call Customer Care at (800) 279-1301.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Dean Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al Customer Care. (800) 279-1301.

Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Dean Health Plan, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau Customer Care. (800) 279-1301.

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Dean Health Plan 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 Customer Care. (800) 279-1301。

Falls Sie oder jemand, dem Sie helfen, Fragen zum Dean Health Plan haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer (800) 279-1301 an.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Plan Health Dean فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ (800) 279-1301

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Dean Health Plan, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону Customer Care. (800) 279-1301.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Dean Health Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 (800) 279-1301 로 전화하십시오.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Dean Health Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi Customer Care. (800) 279-1301.

Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Dean Health Plan, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du (800) 279-1301 uffrufe.

ຖ້າທ່ານ, ຫຼືນິທທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມຄີຳຖາມກ່ຽວກບັ Dean Health Plan, ທ່ານມສີິດທ່ຈະໄດຮ້ັບການຊ່ວຍເຫຼືອແລະຂມ້ນູຂ່າວສານທ່ເປັນພາສາຂອງທ່ານບມ່ຄີ່າໃຊຈ້ ່າຍ. ການໂອລ້ ມ່ກັບນ ່ ายพาสา, ใหโ้ทหา Customer Care. (800) 279-1301.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Dean Health Plan, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez Customer Care. (800) 279-1301.

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Dean Health Plan, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer Customer Care. (800) 279-1301

यदि आपके ,या आप द्वारा सहायता किए जा रहे किसी व्यक्ति के Dean Health Plan के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी दुभाषिए से बात करने के लिए , (800) 279-1301 पर कॉल करें।

Nëse ju, ose dikush që po ndihmoni, ka pyetje për Dean Health Plan, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin Customer Care. (800) 279-1301.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Dean Health Plan, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa Customer Care. (800) 279-1301.

Non-Discrimination Statement: Dean Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Dean Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Dean Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Dean Health Plan provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact the Dean Health Plan Customer Care Center at (800) 279-1301. If you believe that Dean Health Plan 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. If you need help filing a grievance, Megan Simpson, Civil Rights Coordinator for Dean Health Plan is available to help you. You can file a grievance in person or by mail, fax, or email:

Megan Simpson, Civil Rights Coordinator
1277 Deming Way
Madison, Wisconsin 53717
Phone: (608) 828-2216
Email: civilrightscoordinator@deancare.com

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 https://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
1-800-368-1019, 800-537-7697 (TDD)

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://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/** or call (800) 279-1301 or TTY 711. 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 https://www.dol.gov/ebsa/healthreform or https://www.healthcare.gov/sbc-glossary or call (800) 279-1301 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0/individual network $0/family network $250/individual out-of-network $500/family out-of-network	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
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 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?	For network providers $7150 individual / $14300 family; for out-of-network providers $14300 individual / $28600 family. Included in the out-of-pocket limit for covered network services is a deductible and coinsurance limit, which for covered network services is $0 individual / $0 family. There is a deductible and coinsurance limit for covered out-of-network services, which is $500 individual / $1000 family.	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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balanced-billing charges, penalties for failure to obtain pre-authorization, and	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

	health care this plan doesn't cover.	
Will you pay less if you use a network provider?	Yes. See http://www.deancare.com/find-a-doc/ or call 1-800-279-1301 or TTY 711 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 **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
		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 copay/visit	20% coinsurance after deductible	No coverage for Chiropractic maintenance or long-term therapy.
	Specialist visit	$20 copay/visit	20% coinsurance after deductible	Infertility services are covered at 50% of $4,000 life time maximum.
	Preventive care/screening/ immunization	$0 copay/visit	20% coinsurance after deductible	Services under the ACA guidelines will be covered as preventive. Services may have a limit on number of visits and/or specific age requirements. For additional information please see the Preventive Services section in your Member Certificate. 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)	0% coinsurance after deductible	20% coinsurance after deductible	Certain covered diagnostic tests and/or imaging may require written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Imaging (CT/PET scans, MRIs)	PET: 0% coinsurance after deductible CT/MRI: $0 copay/visit	20% coinsurance after deductible	

* For more information about limitations and exceptions, see the plan or policy document at https://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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.deancare.com/pharmacy	Generic drugs (Tier 1)	$6 copay / prescription (retail)	50% coinsurance / prescription (retail)	For mail order maintenance prescriptions, a 90-day supply (Tiers 1 & 2) for 2 copays; 90-day supply (Tier 3) for 3 copays.
	Preferred brand drugs (Tier 2)	$20 copay / prescription (retail)	50% coinsurance / prescription (retail)	
	Non-preferred brand drugs (Tier 3)	$30 copay / prescription (retail)	Not covered (retail and mail order)	
	Specialty drugs	50% coinsurance for infertility drugs/prescription (retail)	Not covered (retail and mail order)	Tobacco cessation products will be covered with a $0 copay if member enrolls in the Quit for Life program. Failure to enroll in Quit for Life will result in not covered Tobacco cessation products.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	20% coinsurance after deductible	Outpatient hospital services require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Physician/surgeon fees	0% coinsurance after deductible	20% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Copay is waived if admitted for observation or inpatient.
	Emergency medical transportation	0% coinsurance after deductible	0% coinsurance after in-network deductible	None
	Urgent care	$20 copay/visit	$20 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	20% coinsurance after deductible	Inpatient hospital services require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Physician/surgeon fees	0% coinsurance after deductible	20% coinsurance after deductible	

* For more information about limitations and exceptions, see the plan or policy document at https://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 copay/visit	$0 copay/visit	Outpatient mental health services require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Inpatient services	$0 copay/admission	$0 copay/admission	Inpatient mental health services require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
If you are pregnant	Office visits	$20 copay/visit	20% coinsurance after deductible	Home or intentional out of hospital deliveries are not covered. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance after deductible	20% coinsurance after deductible	
	Childbirth/delivery facility services	0% coinsurance after deductible	20% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	20% coinsurance after deductible	60 visits/contract period. Services for home health require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Rehabilitation services	0% coinsurance after deductible	20% coinsurance after deductible	Rehabilitation care - 90 days/contract period PT/OT/ST - 60 visits/contract period Services for custodial care are a policy exclusion. Services for rehabilitation care and PT/OT/ST require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per

* For more information about limitations and exceptions, see the plan or policy document at https://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				occurrence.
	Habilitation services	0% coinsurance after deductible	20% coinsurance after deductible	Habilitative therapies - 60 visits/contract period. Services for custodial care are a policy exclusion. Habilitation services require written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Skilled nursing care	0% coinsurance after deductible	20% coinsurance after deductible	30 days/confinement. Services for skilled nursing require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Durable medical equipment	0% coinsurance after deductible	50% coinsurance after deductible; not subject to out-of-pocket maximum	Durable medical equipment over $500 requires a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Hospice services	0% coinsurance after deductible	20% coinsurance after deductible	Services for hospice require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
If your child needs dental or eye care	Children's eye exam	$20 copay/visit	20% coinsurance after deductible	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

* For more information about limitations and exceptions, see the plan or policy document at https://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric Surgery
- Cosmetic services including surgery
- Dental care (Adult)
- Glasses
- Long-term care
- Non-emergency care when travelling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform. 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 assistance, contact: Wisconsin Office of the Commissioner of Insurance at (800) 236-8517 or http://oci.wi.gov/ or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform.

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 plan meet the Minimum Value Standards? **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:

* For more information about limitations and exceptions, see the plan or policy document at https://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/.

Spanish (Español): Para obtener asistencia en Español, llame al: (800) 279-1301 or TTY 711.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa: (800) 279-1301 or TTY 711.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码: (800) 279-1301 or TTY 711.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne': (800) 279-1301 or TTY 711.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at https://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/.

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	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$80**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$620**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)s*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$40**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Assistance – General Taglines

Dean Health Plan is required by federal law to provide the following information.

If you, or someone you're helping, have questions about Dean Health Plan, you have the right to get help and information in your preferred language at no cost. To talk with an interpreter, call Customer Care at (800) 279-1301.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Dean Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al Customer Care. (800) 279-1301.

Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Dean Health Plan, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau Customer Care. (800) 279-1301.

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Dean Health Plan 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 Customer Care. (800) 279-1301。

Falls Sie oder jemand, dem Sie helfen, Fragen zum Dean Health Plan haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer (800) 279-1301 an.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Plan Health Dean فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ (800) 279-1301

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Dean Health Plan, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону Customer Care. (800) 279-1301.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Dean Health Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 (800) 279-1301 로 전화하십시오.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Dean Health Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi Customer Care. (800) 279-1301.

Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Dean Health Plan, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du (800) 279-1301 uffrufe.

ຖ້າທ່ານ, ຫຼືນິທທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມຄີຳຖາມກ່ຽວກບັ Dean Health Plan, ທ່ານມສີິດທ່ຈະໄດຮ້ັບການຊ່ວຍເຫຼືອແລະຂມ້ນູຂ່າວສານທ່ເປັນພາສາຂອງທ່ານບມ່ຄີ່າໃຊຈ້ ່າຍ. ການໂອລ້ ມ່ກັບນ ່ ายพาสา, ใหโ้ทหา Customer Care. (800) 279-1301.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Dean Health Plan, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez Customer Care. (800) 279-1301.

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Dean Health Plan, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer Customer Care. (800) 279-1301

यदि आपके ,या आप द्वारा सहायता किए जा रहे किसी व्यक्ति के Dean Health Plan के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी दुभाषिए से बात करने के लिए , (800) 279-1301 पर कॉल करें।

Nëse ju, ose dikush që po ndihmoni, ka pyetje për Dean Health Plan, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin Customer Care. (800) 279-1301.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Dean Health Plan, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa Customer Care. (800) 279-1301.

Non-Discrimination Statement: Dean Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Dean Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Dean Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Dean Health Plan provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact the Dean Health Plan Customer Care Center at (800) 279-1301. If you believe that Dean Health Plan 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. If you need help filing a grievance, Megan Simpson, Civil Rights Coordinator for Dean Health Plan is available to help you. You can file a grievance in person or by mail, fax, or email:

Megan Simpson, Civil Rights Coordinator
1277 Deming Way
Madison, Wisconsin 53717
Phone: (608) 828-2216
Email: civilrightscoordinator@deancare.com

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 https://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
1-800-368-1019, 800-537-7697 (TDD)

Unity Health Insurance
Affiliated with UW Health

MIDDLETON-CROSS PLAINS AREA SCHOOL DISTRICT
9075794 - POS

Coverage Period: 10/1/2017 - 9/30/2018
Coverage for: Single/Family| **Plan Type:** POS

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: **$0** per Calendar Year Out of Network: **$250** Single/**$500** Family per Calendar 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
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: **$500** Single/**$1,000** Family per Calendar Year for medical expenses. **$2,000** Single/**$4,000** Family per Calendar Year for prescription expenses. Out of Network: **$500** Single/**$1,000** Family per Calendar Year for medical expenses. **$2,000** Single/**$4,000** Family per Calendar Year for prescription expenses.	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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been 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 copay/visit	20% coinsurance after deductible	e-Visits for dependent members under the age of 26 are covered with a $10 copay. e-Visits for all other members are covered with a $10 copay.
	Specialist visit	$20 copay/visit	20% coinsurance after deductible	----------none----------
	Other practitioner office visit	Chiro/Adult Vision: $20 copay/visit	Chiro/Adult Vision: 20% coinsurance after deductible.	No coverage for Out-of-Network Hearing Exams. 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	20% 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.

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 have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	----------none----------
	Imaging (CT/PET scans, MRIs)	No charge	No charge	----------none----------
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	$6 copay	$6 copay	Multiple copays will apply for claims of greater than 30 day supply when covered; for claims of 31 to 60 days supply, two copays will apply, and for claims of 61 to 90 days supply, three copays will apply.
	Preferred Brands | Tier 2	$20 copay	$20 copay	
	Non-Preferred Brands & Generics | Tier 3	$30 copay	$30 copay	
	Specialty drugs | Tier 4	$20 copay for Preferred $30 copay for Non-preferred	$20 copay for Preferred $30 copay for Non-preferred	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% 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	No charge	20% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	----------none----------
	Emergency medical transportation	No charge	No charge	----------none----------
	Urgent care	$20 copay/visit	20% coinsurance after deductible	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% 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	No charge	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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	20% coinsurance after deductible	Benefits are not available for care that is Maintenance and Supportive Care or Long-term therapy.
	Inpatient services	No charge	20% 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 copay/visit	20% coinsurance after deductible	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). 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.
	Childbirth/delivery professional services	No charge	20% coinsurance after deductible	
	Childbirth/delivery facility services	No charge	20% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance after deductible	Coverage is limited to 60 visits per Calendar 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	No charge	20% coinsurance after deductible	The first 15 visits for Physical, Speech & Occupational Therapy are covered with no prior authorization. After 15 visits, prior authorization is required. Cardiac Rehab is limited to 36 visits per event.
	Habilitation services	No charge	20% 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.

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)	
	Skilled nursing care	No charge	20% 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.
	Durable medical equipment	No charge	No charge	Coverage for -- Foot Orthotics: Limited to one pair per Calendar 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	No charge	20% 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 Calendar 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	• Dental care (Adult)	• Private-duty nursing
• Bariatric surgery	• Long-term care	• Routine foot care
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• 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.)	
• Chiropractic care	• Infertility treatment
• 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	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$310**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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*	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$900**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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*	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$100**

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

MIDDLETON-CROSS PLAINS AREA SCHOOL DISTRICT
9067065 - HMO Copay

Coverage Period: 10/1/2017 - 9/30/2018
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?	**$0** per Calendar Year	See the Common Medical Events chart below for your costs for services this plan covers.
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?	**$4,600** Single/**$9,200** Family per Calendar Year for medical expenses. **$2,000** Single/**$4,000** Family per Calendar Year for prescription expenses.	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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been 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	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

	referral is required.	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 copay/visit	Not Covered	e-Visits for dependent members under the age of 26 are covered with a $10 copay. e-Visits for all other members are covered with a $10 copay.
	Specialist visit	$20 copay/visit	Not Covered	----------none----------
	Other practitioner office visit	Chiro/Adult Vision: $20 copay/visit	Not Covered	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	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)	No charge	Not Covered	----------none----------
	Imaging (CT/PET scans, MRIs)	MRI/MRA: No charge CT: No charge PET: No charge	Not Covered	----------none----------
If you need drugs to treat your illness or condition More information about	Preferred Generics | Tier 1	$6 copay	$6 copay	Multiple copays will apply for claims of greater than 30 day supply when covered; for claims of 31 to 60 days supply, two copays will apply, and for claims of 61 to 90 days supply, three copays will apply.
	Preferred Brands | Tier 2	$20 copay	$20 copay	
	Non-Preferred Brands & Generics | Tier 3	$30 copay	$30 copay	

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)	
prescription drug coverage is available at www.unityhealth.com/drugformulary	Specialty drugs | Tier 4	$20 copay for Preferred $30 copay for Non-preferred	$20 copay for Preferred $30 copay for Non-preferred	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	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	No charge	Not Covered	
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	----------none----------
	Emergency medical transportation	No charge	No charge	----------none----------
	Urgent care	$20 copay/visit	$20 copay/visit	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	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	No charge	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	Not Covered	Benefits are not available for care that is Maintenance and Supportive Care or Long-term therapy.
	Inpatient services	No charge	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 copay/visit	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). 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.
	Childbirth/delivery professional services	No charge	Not Covered	
	Childbirth/delivery facility services	No charge	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)	
If you need help recovering or have other special health needs	Home health care	No charge	Not Covered	Coverage is limited to 60 visits per Calendar 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	No charge	Not Covered	The first 15 visits for Physical, Speech & Occupational Therapy are covered with no prior authorization. After 15 visits, prior authorization is required. Cardiac Rehab is limited to 36 visits per event.
	Habilitation services	No charge	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.
	Skilled nursing care	No charge	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.
	Durable medical equipment	No charge	Not Covered	Coverage for -- Foot Orthotics: Limited to one pair per Calendar 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.

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)	
	Hospice services	No charge	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 Calendar 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
- Dental care (Adult)
- 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.)

- Chiropractic care
- Hearing aids
- Infertility treatment
- 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	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$310**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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*	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$900**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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*	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$100**

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.