

2017-18 INSURANCE RATES MONTHLY PREMIUMS

(Effective June 2017 - May 2018)

	Premium	Full-time Board's Share 80%	Full-time Employee Share 20%	
HEALTH PLANS (Health insurance is only available for employees with an FTE = > .75FTE. See Eligibility below)				
UNITY PLAN - HMO (In Network) Deductible: \$500 single/\$1000 family, Co-insurance: 10% Employee.				
Family	1458.42	1166.74	291.68	
Single	643.10	514.48	128.62	
UNITY PLAN - POS (IN & OUT of Network) Deductible: \$1000 single/\$2000 family, Co-insurance: 20% Employee				
Family	1625.19	1300.15	325.04	
Single	716.13	572.91	143.22	
DELTA DENTAL				
Family	104.48	83.58	20.90	
Single	40.56	32.45	8.11	*prorated for part-time – see dental rate sheet
WEA- Life Ins per month	.118/1000	100%	.00	Supplemental life available at rates based on age and elected amount. See sum life sheet.
MNLI - LTD Ins per year	.31/100	100%	.00	

Eligibility:

- Regular employee who is contracted/assigned to work at least 30 hours per week is eligible for health insurance.
 - Teachers, secretaries/specialists, custodians, food nutrition, m/m/ds & administrators - equal/greater than a .75 FTE (30/40hrs)
 - Paraprofessionals – equal/greater than a .8 FTE (30/37.5hrs)
 - Other employees (such as substitutes, coach, tutor etc) will be notified of their health insurance eligibility by mail if worked an average of 30 hours per week per the ACA regulations.
- Dental, Life and LTD is only available to regular employees scheduled to work at least 20 hours per week.
- *Dental insurance is prorated for part time employees based on FTE as noted above.

Payroll Deductions:

- The employee share is deducted at ½ the monthly amount on the first two checks paid each month.
- New hires and "late enrollee" will pay an accelerated "Catch-up" amount, and then will be on the same schedule as the employee type in the group they belong.
- School year hourly employees (i.e. Paraprofessional, Food Service, 225/210 Secretaries and Interpreters will have their share of the summer insurance (July & August) deducted in April & May each year.
- **Teachers who have their contract paid over 10 months will pay their share of the July & August insurance on their last check in June.**

The employee is responsible to apply for insurance within 30 days of the qualifying event. i.e. New Hire, change in job status, lost of other coverage, change in family/marital status, change in dependents etc. Call Benefits Specialist (ext. 8707) or 781-9707 for enrollment or changes in coverage.


Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services



School District of Onalaska
9077321 - POS

Coverage Period: 7/1/2017 - 6/30/2018

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 <u>deductible</u> ?	In <u>Network</u> : \$500 Single/ \$1,000 Family per Benefit Year Out of <u>Network</u> : \$1,000 Single/ \$2,000 Family per Benefit Year	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without cost-sharing and before you meet your <u>deductible</u> . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In <u>Network</u> : \$1,000 Single/ \$2,000 Family per Benefit Year for medical expenses. \$2,000 Single/ \$4,000 Family per Benefit Year for prescription expenses. Out of <u>Network</u> : \$4,000 Single/ \$8,000 Family per Benefit Year for medical expenses. \$2,000 Single/ \$4,000 Family per Benefit Year for prescription expenses.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , balance-billing charges, penalties for failure to obtain prior authorization, dental <u>coinsurance</u> , and health care this <u>plan</u>	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Questions: Call 1-800-362-3310 or visit us at www.unityhealth.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.unityhealth.com/glossary or call 1-800-362-3310 to request a copy.

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POS SBC
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	doesn't cover.	
Will you pay less if you use a <u>network provider</u>?	Yes. See www.unityhealth.com/findadoctor or call 1-800-362-3310 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an out-of- <u>network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an out-of- <u>network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit 10% <u>coinsurance</u> after <u>deductible</u> for other outpatient services.	20% <u>coinsurance</u> after <u>deductible</u>	e-Visits for dependent members under the age of 26 are covered with a \$15 <u>copay</u> . e-Visits for all other members are covered with a \$15 <u>copay</u> .
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit 10% <u>coinsurance</u> after <u>deductible</u> for other outpatient services.	20% <u>coinsurance</u> after <u>deductible</u>	-----none-----
	Other practitioner office visit	Chiro/Adult Vision: \$25 <u>copay</u> /visit 10% <u>coinsurance</u> after <u>deductible</u> for other outpatient services.	Chiro/Adult Vision: 20% <u>coinsurance</u> after <u>deductible</u> .	No coverage for Out-of- <u>Network</u> Hearing Exams. Benefits are not available for care that is Maintenance and Supportive Care or Long-term Therapy. Adult eyewear coverage is limited to \$150 per Benefit Year.
	<u>Preventive care/screening/immunization</u>	No charge	20% <u>coinsurance</u> after <u>deductible</u>	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 <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> 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	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	-----none-----
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.unityhealth.com/drugformulary	Preferred Generics Tier 1	\$5 <u>copay</u>	\$5 <u>copay</u>	Multiple <u>copays</u> will apply for <u>claims</u> of greater than 30 day supply when covered; for <u>claims</u> of 31 to 60 days supply, two <u>copays</u> will apply, and for <u>claims</u> of 61 to 90 days supply, three <u>copays</u> will apply.
	Preferred Brands Tier 2	\$25 <u>copay</u>	\$25 <u>copay</u>	
	Non-Preferred Brands & Generics Tier 3	\$40 <u>copay</u>	\$40 <u>copay</u>	
	<u>Specialty drugs</u> Tier 4	\$200 <u>copay</u>	\$200 <u>copay</u>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	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	10% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit	-----none-----
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u> after <u>deductible</u>	10% <u>coinsurance</u> after <u>deductible</u>	-----none-----
	<u>Urgent care</u>	\$25 <u>copay</u> /visit	20% <u>coinsurance</u> after <u>deductible</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	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	10% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	

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	\$25 <u>copay</u> /visit 10% <u>coinsurance</u> after <u>deductible</u> for other outpatient services.	20% <u>coinsurance</u> after <u>deductible</u>	Benefits are not available for care that is Maintenance and Supportive Care or Long-term therapy.
	Inpatient services	10% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	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	\$25 <u>copay</u> /visit 10% <u>coinsurance</u> after <u>deductible</u> for other outpatient services.	20% <u>coinsurance</u> after <u>deductible</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	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 facility services	10% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	
If you need help recovering or have other special health needs	Home health care	10% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	Coverage is limited to 60 visits per Benefit Year. Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.

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)	
	<u>Rehabilitation services</u>	10% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	<p>Coverage for Physical, Speech and Occupational therapy is limited to a combined total of 40 visits per Benefit Year.</p> <p>Coverage is limited to 0 visits each for Physical, Speech and Occupational therapy and Pulmonary Rehab per Benefit Year.</p> <p>Cardiac Rehab is limited to 36 visits per event.</p> <p>Cardiac Rehab is limited to 0 visits per Benefit Year.</p> <p>Inpatient Rehab is limited to 0 days per Benefit Year.</p> <p>Post Cochlear Implant Aural Therapy is limited to 0 visits per Benefit Year.</p>
	<u>Habilitation services</u>	10% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	<p>Coverage for Physical, Speech and Occupational therapy is limited to a combined total of 40 visits per Benefit Year.</p> <p>Coverage is limited to 0 visits each for Physical, Speech and Occupational therapy per Benefit Year.</p> <p>Prior Authorization may be required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.</p>

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)	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	Coverage limited to 0 days per Benefit Year. Prior Authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	Coverage for -- Foot Orthotics: Limited to one pair per Benefit Year. Hearing Aids: Limited to one per ear every 36 months. To obtain the list of covered hearing aid models log onto unityhealth.com/hearing_aids or contact Customer Service. Prior authorization may be required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	<u>Hospice services</u>	10% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	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% <u>coinsurance</u> after <u>deductible</u>	Limited to one exam per Benefit Year.
	Children's glasses	No charge	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	-----none-----

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u>.)		
• Acupuncture	• Infertility treatment	• Private-duty nursing

- Cosmetic surgery
- Dental care (Adult)

- Long-term care
- Non-emergency care when traveling outside the U.S.

- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care

- Hearing aids
- Routine eye care (Adult)

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or for assistance, contact: Office of the Commissioner of Insurance, Complaints Department, PO Box 7873, Madison, WI 53707-7873, or if coverage is under a group health plan the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Does this Plan Provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-362-3310 or 1-800-877-8973 (TTY).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-362-3310 or 1-800-877-8973 (TTY)

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-362-3310 or 1-800-877-8973 (TTY)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo 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](#) \$500
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$400
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Peg would pay is	\$1,010

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$100
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,000

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$500
Copayments	\$200
Coinsurance	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$760

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 nyooog ceeb hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam kom tsis pub dhau cov caij nyooog koj thiab yuav tau txais kev pab kam them nqi kho mob los yog kev pab kam 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。本通知包含了關於您通過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採取行動，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 bản 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 giúp 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 Bekanntmachung gebt wichdichi Auskunft. Die Bekanntmachung 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 beschtimme Deadlines, so ass du dei Health Coverage bhalde kantscht, odder bezaahle helfe kantscht. Du hoscht es Recht fer die Information un Hilf in deine eegne Schpreech griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kantscht du (800) 362-3310 uffrufe. TTY / TDD: 711 / (800) 877-8973.

Laotian – ແຈ້ງການນີ້ມີຂໍ້ມູນສໍາຄັນ. ແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບການສະໜັບສະໜູ່ ຫຼື ການຄຸ້ມຄອງຂອງທ່ານ ໂດຍຜ່ານ Unity. ໃຫ້ເບິ່ງກຳນົດວັນທີ່ສໍາຄັນຢູ່ໃນແຈ້ງການນີ້. ທ່ານອາດຈະຕ້ອງໄດ້ໃຊ້ເວລາດຳເນີນການຕາມກຳນົດເວລາທີ່ແນ່ນອນ ເພື່ອຮັກສາການຄຸ້ມຄອງຂອງທ່ານ ຫຼື ການຊ່ວຍເຫຼືອທີ່ມາໃຊ້ຈ່າຍ. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນຂາວສານ 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 में 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 ndërmerreni 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.

UH01647 (0916)

Questions: Call 1-800-362-3310 or visit us at www.unityhealth.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.unityhealth.com/glossary or call 1-800-362-3310 to request a copy.

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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.

Questions: Call 1-800-362-3310 or visit us at www.unityhealth.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.unityhealth.com/glossary or call 1-800-362-3310 to request a copy.

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