Unity Health Insurance
Affiliated with UW Health

RIVERDALE SCHOOL DISTRICT
9082017 - HMO Deductible

Coverage Period: 9/1/2017 - 8/31/2018
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?	**$2,000** Single/**$4,000** Family per Benefit Year	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the 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?	**$3,000** Single/**$6,000** Family per Benefit Year for medical expenses. **$2,000** Single/**$4,000** Family per Benefit 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	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

	providers.	for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	In-Network providers: No. Out-of-Network providers: Yes, written referral is required.	In-Network: You can see the specialist you choose without a referral. Out-of-Network: This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge after deductible	Not Covered	Charges for e-Visits will apply to your deductible/coinsurance.
	Specialist visit	No charge after deductible	Not Covered	----------none----------
	Other practitioner office visit	Chiro/Adult Vision: No charge after deductible	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 after deductible	Not Covered	----------none----------
	Imaging (CT/PET scans, MRIs)	MRI/MRA: No charge after deductible CT: No charge after deductible PET: No charge after deductible	Not Covered	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.unityhealth.com/drugformulary	Preferred Generics | Tier 1	Value Tier: $0 copay All others: $5 copay	Value Tier: $0 copay All others: $5 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	Value Tier: $0 copay All others: $20 copay	Value Tier: $0 copay All others: $20 copay	
	Non-Preferred Brands & Generics | Tier 3	$40 copay	$40 copay	
	Specialty drugs | Tier 4	$20 copay for Preferred $40 copay for Non-preferred	$20 copay for Preferred $40 copay for Non-preferred	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	Not Covered	Prior authorization may be required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Physician/surgeon fees	No charge after deductible	Not Covered	
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	----------none----------
	Emergency medical transportation	No charge after deductible	No charge after deductible	----------none----------
	Urgent care	$25 copay/visit	$25 copay/visit	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	Not Covered	Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Physician/surgeon fees	No charge after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after deductible	Not Covered	Benefits are not available for care that is Maintenance and Supportive Care or Long-term therapy.
	Inpatient services	No charge after deductible	Not Covered	Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
If you are pregnant	Office visits	No charge after deductible	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge after deductible	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
	Childbirth/delivery facility services	No charge after deductible	Not Covered	Prior authorization is required for inpatient services. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not Covered	Coverage is limited to 60 visits per Benefit Year. Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Rehabilitation services	No charge after deductible	Not Covered	Coverage for Physical, Speech and Occupational therapy is limited to a combined total of 40 visits per Benefit Year. Cardiac Rehab is limited to 36 visits per event.
	Habilitation services	No charge after deductible	Not Covered	Coverage for Physical, Speech and Occupational therapy is limited to a combined total of 40 visits per Benefit Year. Prior Authorization may be required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Skilled nursing care	No charge after deductible	Not Covered	Coverage limited to 90 days per confinement. Prior Authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
	Durable medical equipment	No charge after deductible	Not Covered	Coverage for -- Foot Orthotics: Limited to one pair per Benefit Year. Hearing Aids: Limited to one per ear every 36 months. To obtain the list of covered hearing aid models log onto unityhealth.com/hearing aids or contact Customer Service. Prior authorization may be required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Hospice services	No charge after deductible	Not Covered	Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
If your child needs dental or eye care	Children's eye exam	No charge	Not Covered	Limited to one exam per Benefit Year.
	Children's glasses	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	**$2,000**
Specialist copayment	**Deductible**
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	$2,000
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$2,030**

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

The plan's overall deductible	**$2,000**
Specialist copayment	**Deductible**
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*	$1,200
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,200**

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

The plan's overall deductible	**$2,000**
Specialist copayment	**Deductible**
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*	$1,400
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

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

RIVERDALE SCHOOL DISTRICT
9082056 - HMO Deductible

Coverage Period: 9/1/2017 - 8/31/2018
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?	**$100** Single/**$200** Family per Benefit Year	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the 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?	**$1,100** Single/**$2,200** Family per Benefit Year for medical expenses. **$2,000** Single/**$4,000** Family per Benefit 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	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

	providers.	for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	In-Network providers: No. Out-of-Network providers: Yes, written referral is required.	In-Network: You can see the specialist you choose without a referral. Out-of-Network: This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/visit	Not Covered	e-Visits for dependent members under the age of 26 are covered with a $5 copay. e-Visits for all other members are covered with a $5 copay.
	Specialist visit	$10 copay/visit	Not Covered	----------none----------
	Other practitioner office visit	Chiro/Adult Vision: $10 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 after deductible	Not Covered	----------none----------
	Imaging (CT/PET scans, MRIs)	MRI/MRA: No charge after deductible CT: No charge after deductible PET: No charge after deductible	Not Covered	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.unityhealth.com/drugformulary	Preferred Generics | Tier 1	Value Tier: $0 copay All others: $5 copay	Value Tier: $0 copay All others: $5 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	Value Tier: $0 copay All others: $20 copay	Value Tier: $0 copay All others: $20 copay	
	Non-Preferred Brands & Generics | Tier 3	$40 copay	$40 copay	
	Specialty drugs | Tier 4	$20 copay for Preferred $40 copay for Non-preferred	$20 copay for Preferred $40 copay for Non-preferred	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	Not Covered	Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Physician/surgeon fees	No charge after deductible	Not Covered	
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	----------none----------
	Emergency medical transportation	No charge after deductible	No charge after deductible	----------none----------
	Urgent care	No charge	No charge	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	Not Covered	Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Physician/surgeon fees	No charge after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/visit	Not Covered	Benefits are not available for care that is Maintenance and Supportive Care or Long-term therapy.
	Inpatient services	No charge after deductible	Not Covered	Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
If you are pregnant	Office visits	$10 copay/visit	Not Covered	Maternity care may include tests and services described elsewhere within this document (i.e. ultrasound).
	Childbirth/delivery professional services	No charge after deductible	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
	Childbirth/delivery facility services	No charge after deductible	Not Covered	Prior authorization is required for inpatient services. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not Covered	Coverage is limited to 60 visits per Benefit Year. Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Rehabilitation services	No charge after deductible	Not Covered	Coverage for Physical, Speech and Occupational therapy is limited to a combined total of 40 visits per Benefit Year. Cardiac Rehab is limited to 36 visits per event.
	Habilitation services	No charge after deductible	Not Covered	Coverage for Physical, Speech and Occupational therapy is limited to a combined total of 40 visits per Benefit Year. Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Skilled nursing care	No charge after deductible	Not Covered	Coverage limited to 90 days per confinement. Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
	Durable medical equipment	No charge after deductible	Not Covered	Coverage for -- Foot Orthotics: Limited to one pair per Benefit Year. Hearing Aids: Limited to one per ear every 36 months. To obtain the list of covered hearing aid models log onto unityhealth.com/hearingaids or contact Customer Service. Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Hospice services	No charge after deductible	Not Covered	Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
If your child needs dental or eye care	Children's eye exam	No charge	Not Covered	Limited to one exam per Benefit Year.
	Children's glasses	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	**$100**
Specialist copayment	**$10**
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	$100
Copayments	$200
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	**$100**
Specialist copayment	**$10**
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*	$100
Copayments	$80
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$180**

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

The plan's overall deductible	**$100**
Specialist copayment	**$10**
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*	$100
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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

RIVERDALE SCHOOL DISTRICT
9077377 - POS

Coverage Period: 9/1/2017 - 8/31/2018
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: **$100** Single/**$200** Family per Benefit Year Out of Network: **$200** Single/**$400** Family per Benefit Year	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the 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: **$1,100** Single/**$2,200** Family per Benefit Year for medical expenses. **$2,000** Single/**$4,000** Family per Benefit Year for prescription expenses. Out of Network: **$3,200** Single/**$6,400** Family per Benefit Year for medical expenses. **$2,000** Single/**$4,000** Family per Benefit 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	$10 copay/visit	20% coinsurance after deductible	e-Visits for dependent members under the age of 26 are covered with a $5 copay. e-Visits for all other members are covered with a $5 copay.
	Specialist visit	$10 copay/visit	20% coinsurance after deductible	----------none----------
	Other practitioner office visit	Chiro/Adult Vision: $10 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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible	20% coinsurance after deductible	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	No charge after deductible	20% coinsurance after deductible	----------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	Value Tier: $0 copay All others: $5 copay	Value Tier: $0 copay All others: $5 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	Value Tier: $0 copay All others: $20 copay	Value Tier: $0 copay All others: $20 copay	
	Non-Preferred Brands & Generics | Tier 3	$40 copay	$40 copay	
	Specialty drugs | Tier 4	$20 copay for Preferred $40 copay for Non-preferred	$20 copay for Preferred $40 copay for Non-preferred	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	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 after deductible	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 after deductible	No charge after deductible	----------none----------
	Urgent care	No charge	20% coinsurance after deductible	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	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 after deductible	20% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 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 after deductible	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	$10 copay/visit	20% coinsurance after deductible	Maternity care may include tests and services described elsewhere within this document (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 after deductible	20% coinsurance after deductible	
	Childbirth/delivery facility services	No charge after deductible	20% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	No charge after deductible	20% coinsurance after deductible	Coverage is limited to 60 visits per Benefit Year. Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Rehabilitation services	No charge after deductible	20% coinsurance after deductible	Coverage for Physical, Speech and Occupational therapy is limited to a combined total of 40 visits per Benefit Year. Cardiac Rehab is limited to 36 visits per event.

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)	
	Habilitation services	No charge after deductible	20% coinsurance after deductible	Coverage for Physical, Speech and Occupational therapy is limited to a combined total of 40 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.
	Skilled nursing care	No charge after deductible	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 after deductible	20% coinsurance	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/hearingaids or contact Customer Service. Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Hospice services	No charge after deductible	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 Benefit Year.

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)	
	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	$100
Specialist copayment	$10
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	$100
Copayments	$200
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	$100
Specialist copayment	$10
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*	$100
Copayments	$80
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$180**

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

The plan's overall deductible	$100
Specialist copayment	$10
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*	$100
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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

RIVERDALE SCHOOL DISTRICT
9036291 - PPO

Coverage Period: 9/1/2017 - 8/31/2018
Coverage for: Single/Family| **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **https://unityhealth.com/apps/CertLookup**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **www.unityhealth.com** or call 1-800-362-3310 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In Network: **$2,000** Single/**$4,000** Family per Benefit Year Out of Network: **$2,000** Single/**$4,000** Family per Benefit Year	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the 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: **$3,000** Single/**$6,000** Family per Benefit Year for medical expenses. **$2,000** Single/**$4,000** Family per Benefit Year for prescription expenses. Out of Network: **$6,000** Single/**$12,000** Family per Benefit Year for medical expenses. **$2,000** Single/**$4,000** Family per Benefit 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	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 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	No charge after deductible	20% coinsurance after deductible	Charges for e-Visits will apply to your deductible/coinsurance.
	Specialist visit	No charge after deductible	20% coinsurance after deductible	----------none----------
	Other practitioner office visit	Chiro/Adult Vision: No charge after deductible	Chiro/Adult Vision: 20% coinsurance after deductible.	Benefits are not available for care that is Maintenance and Supportive Care or Long-term Therapy. Glasses/contacts for Adult Routine Vision are not covered.
	Preventive care/screening/ immunization	No charge	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible	20% coinsurance after deductible	----------none----------
	Imaging (CT/PET scans, MRIs)	No charge after deductible	20% coinsurance after deductible	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.unityhealth.com/drugformulary	Preferred Generics | Tier 1	Value Tier: $0 copay All others: $5 copay	Value Tier: $0 copay All others: $5 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	Value Tier: $0 copay All others: $20 copay	Value Tier: $0 copay All others: $20 copay	
	Non-Preferred Brands & Generics | Tier 3	$40 copay	$40 copay	
	Specialty drugs | Tier 4	$20 copay for Preferred $40 copay for Non-preferred	$20 copay for Preferred $40 copay for Non-preferred	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	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 after deductible	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 after deductible	No charge after deductible	----------none----------
	Urgent care	$25 copay/visit	20% coinsurance after deductible	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	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 after deductible	20% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after deductible	20% coinsurance after deductible	Benefits are not available for care that is Maintenance and Supportive Care or Long-term therapy.
	Inpatient services	No charge after deductible	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	No charge after deductible	20% coinsurance after deductible	Maternity care may include tests and services described elsewhere in the SBC (i.e.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
	Childbirth/delivery professional services	No charge after deductible	20% coinsurance after deductible	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 facility services	No charge after deductible	20% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	No charge after deductible	20% coinsurance after deductible	Coverage is limited to 60 visits per Benefit Year. Prior authorization is required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Rehabilitation services	No charge after deductible	20% coinsurance after deductible	Coverage for Physical, Speech and Occupational therapy is limited to a combined total of 40 visits per Benefit Year. Cardiac Rehab is limited to 36 visits per event.
	Habilitation services	No charge after deductible	20% coinsurance after deductible	Coverage for Physical, Speech and Occupational therapy is limited to a combined total of 40 visits per Benefit Year. Prior Authorization may be required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information.
	Skilled nursing care	No charge after deductible	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
	Durable medical equipment	No charge after deductible	30% coinsurance	Coverage for -- Foot Orthotics: Limited to one pair per Benefit Year. Hearing Aids: Limited to one per ear every 36 months. To obtain the list of covered hearing aid models log onto unityhealth.com/hearing aids or contact Customer Service. Prior authorization may be required. See https://unityhealth.com/members/how-to-get-care/prior-authorization or call Customer Service for additional information. Purchase or rental of DME with a per unit cost of $500 or more must be Prior Authorized.
	Hospice services	No charge after deductible	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 Benefit Year.
	Children's glasses	Not Covered	Not Covered	----------none----------
	Children's dental check-up	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- 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	• 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	**$2,000**
Specialist copayment	**Deductible**
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	$2,000
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$2,030**

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

The plan's overall deductible	**$2,000**
Specialist copayment	**Deductible**
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*	$1,200
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,200**

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

The plan's overall deductible	**$2,000**
Specialist copayment	**Deductible**
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*	$1,400
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

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.