State Uniform Benefits Non-Medicare Community Network

Coverage Period: 1/1/13-12/31/13

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual & Family | Plan Type: HMO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.etf.wi.gov or by calling 1-877-533-5020.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$ 0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Medical: **$500** person/**$1,000** family. Prescription drug Level 1 and 2: **$410** person/**$820** family Formulary specialty drugs: **$1,000** person/**$2,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Emergency room, prescription drug Level 3 and non-formulary specialty drug copayments; coinsurance paid by adults for hearing aids, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.ChooseUnityHealth.com/finda doctor or call 1-800-362-3310 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Questions: Call 1-877-533-5020, visit us at www.etf.wi.gov.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.**etf.wi.gov\publications\IYC\iyc2013\uniform-glossary.pdf** or call 1-877-533-5020 to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Corrected on May 11, 2012

Do I need a referral to see a specialist?	Yes, written referral is required for all out-of-network providers.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	Not covered	——————none——————
	Specialist visit	10% coinsurance	Not covered	——————none——————
	Other practitioner office visit	10% coinsurance for chiropractor	Not covered	Maintenance care and acupuncture not covered.
	Preventive care/screening/immunization	10% coinsurance	Not covered	Full coverage if required by federal law
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	Full coverage if required by federal law
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	In-network services require your practitioner to confirm the need for the study. Out-of-network services require prior authorization.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.navitus.com.	Level 1 Formulary generic drugs and certain low cost brand name drugs	$5/prescription to **out-of-pocket limit**. (2 copays apply to certain 90-day supply mail order.)	Not covered	In-network covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order. Out-of-network emergency or urgent care allowed but if your ID card is not used, you may have to pay more than the copay.
	Level 2 Formulary brand name drugs and certain high cost generic drugs	$15/prescription to **out-of-pocket limit**. (2 copays apply to certain 90-day supply mail order.)	Not covered	In-network covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order. Out-of-network emergency or urgent care allowed but if your ID card is not used, you may have to pay more than the copay.
	Level 3 Non-formulary prescription drugs	$35/prescription	Not covered	No out-of-pocket limit. Out-of-network emergency or urgent care allowed but if your ID card is not used, you may have to pay more than the copay.
	Specialty drugs at preferred provider	$15 Formulary drugs to **out-of-pocket limit**; $50 non-formulary no **out-of-pocket limit**	Not covered	Out-of-network emergency or urgent care allowed but if your ID card is not used, you may have to pay more than the copay.
	Specialty drugs at non-preferred provider	$50 formulary drugs to **out-of-pocket limit**; $50 non-formulary no **out-of-pocket limit**		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	——————none——————
	Physician/surgeon fees	10% coinsurance	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$75 copay then 10% coinsurance	$75 copay then 10% coinsurance	Copay does not apply to **out-of-pocket limit** and waived if admitted.
	Emergency medical transportation	10% coinsurance	10% coinsurance	——————none——————
	Urgent care	10% coinsurance	10% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	——————none——————
	Physician/surgeon fee	10% coinsurance	Not covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	Not covered	——————none——————
	Mental/Behavioral health inpatient services	10% coinsurance	Not covered	——————none——————
	Substance use disorder outpatient services	10% coinsurance	Not covered	——————none——————
	Substance use disorder inpatient services	10% coinsurance	Not covered	——————none——————
If you are pregnant	Prenatal and postnatal care	10% coinsurance	Not covered	——————none——————
	Delivery and all inpatient services	10% coinsurance	Not covered	——————none——————
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	Limited to 50 visits per year. Plan may approve 50 more per year.
	Rehabilitation services	10% coinsurance	Not covered	Physical, speech and occupational therapy limited to 50 visits per year. Plan may approve 50 more per year.
	Habilitation services	Not covered	Not covered	Excluded service.
	Skilled nursing care	10% coinsurance	Not covered	Facility coverage is limited to 120 days per benefit period.
	Durable medical equipment	20% coinsurance (child's hearing aids 10%)	Not covered	Hearing aids (adults) plan maximum payment $1,000 per ear every 3 years. Coinsurance for adults does not apply to **out-of-pocket limit.**
	Hospice service	10% coinsurance	Not covered	——————none——————
If your child needs dental or eye care	Eye exam	10% coinsurance	Not covered	Full coverage if required by federal law. Limited to one per person per year. Contact lens fittings not covered.
	Glasses	Not covered	Not covered	Excluded service.
	Dental check-up	No charge	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	• Infertility treatment	• Routine eye care (glasses)
• Bariatric Surgery	• Long-term care	• Routine foot care
• Cosmetic Surgery	• Non-emergency care when traveling outside US	• Weight loss programs (except nutritional counseling)
• Habilitation services	• Private duty nursing	

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

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-362-3310. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Unity Health Insurance at 1-800-362-3310 or ETF at 1-877-533-5020 or www.etf.wi.gov.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-362-3310 or 608-643-1421 (TTD/TTY).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-362-3310 or 608-643-1421 (TTD/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 608-643-1421 (TTD/TTY).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-362-3310 or 608-643-1421 (TTD/TTY).

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,950
- **Patient pays** $590

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$590
Limits or exclusions	$0
Total	**$590**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,740
- **Patient pays** $660

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays *(Prescription only Tier 1,2)*	$410
Coinsurance	$250
Limits or exclusions	$0
Total	**$660**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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