

Schedule of Benefits - HMO Premier
Group 380 - CITY OF MARSHFIELD
Benefit Year: January 1st through December 31st
Effective Date: 01/01/2020



Security Health Plan certifies that you and any covered dependents have coverage as described in your Certificate and Schedule of Benefits as of the effective date shown on the letter you received with your identification cards, subject to the terms, conditions, exclusions, limitations and all other provisions of the group policy.

This Schedule shows your specific cost-sharing, as well as any additional benefits, limitations or exclusions not shown in your Certificate. It also provides a very general summary of your benefits for certain types of services; **you will need to read it in conjunction with your Certificate for details about your coverage.** Benefits are calculated according to the benefit year shown above. **NOTE: All services must be received from affiliated providers, except as otherwise described in the Certificate.**

Your Responsibilities	
Deductible This plan is intended to qualify as a high deductible health plan that may be paired with a health savings account; however, you should check with your tax advisor for guidance on your particular situation.	\$3,000 per individual \$6,000 per family The family deductible can be met by any combination of members within a family. If one family member meets the individual deductible, the deductible is satisfied for his or her claims. The maximum deductible is equal to the family deductible.
Coinsurance	10% of the next \$5,000 per individual \$10,000 per family
Emergency room facility copayment (Waived if admitted to the hospital as an inpatient)	\$200 copayment per visit After deductible is satisfied, services are subject to coinsurance and copayment.
Annual out-of-pocket (Deductible, coinsurance & copayments)	\$4,500 per individual \$9,000 per family The family annual out of pocket can be met by any combination of members within a family. If one family member meets the individual annual out of pocket, the annual out of pocket is satisfied for his or her claims. The maximum annual out of pocket is equal to the family annual out of pocket.
Dependent wrap coverage In addition to the benefits described in the Follow-up Care section of the Certificate, dependents living outside of the service area are provided benefits for covered services from non-affiliated providers.	Such coverage shall be provided at the in network level of benefits.

Your Benefits	
Ambulance services	Subject to deductible and coinsurance
Anesthesia services	Subject to deductible and coinsurance
Care my way	Covered at 100%
Chiropractic services	Subject to deductible and coinsurance
Durable medical equipment and medical supplies (Including insulin pump and supplies)	Subject to deductible and coinsurance

Your Benefits	
Habilitative therapy	
<ul style="list-style-type: none"> • Occupational therapy 	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Physical therapy 	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Speech therapy 	Subject to deductible and coinsurance
Hearing examinations	Subject to deductible and coinsurance
Home health care	Subject to deductible and coinsurance (Limited to 40 visits per individual per calendar year)
Hospice care	Subject to deductible and coinsurance
Hospital emergency room services	
<ul style="list-style-type: none"> • Emergency room facility (Copayment waived if admitted to hospital as inpatient) 	\$200 copayment per visit After deductible is satisfied, services are subject to coinsurance and copayment.
<ul style="list-style-type: none"> • Other emergency room services 	Subject to deductible and coinsurance
Hospital inpatient services (Including semi-private or special care room, operating room, ancillary services and supplies)	Subject to deductible and coinsurance
Hospital outpatient and surgical center services (Not including emergency room)	Subject to deductible and coinsurance
Maternity services	
<ul style="list-style-type: none"> • Hospital services 	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Physician services 	Subject to deductible and coinsurance
Mental health and substance use disorder services	
<ul style="list-style-type: none"> • Inpatient care 	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Outpatient care 	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Transitional care 	Subject to deductible and coinsurance
Nutritional counseling	Covered at 100% (Limited to 4 visits per calendar year)
Office visits	Subject to deductible and coinsurance (Preventive exams covered at 100%)
Outpatient laboratory services	Subject to deductible and coinsurance

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Outpatient radiology services	Subject to deductible and coinsurance
Physician services	
<ul style="list-style-type: none"> • Hospital services 	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Other services in an office 	Subject to deductible and coinsurance (Preventive immunizations covered at 100%)

Your Benefits	
<p>Preventive benefit Please refer to Security Health Plan's Preventive Service Guidelines at www.securityhealth.org/preventive for service frequency recommendations.</p>	
<ul style="list-style-type: none"> • Comprehensive physical examination (complete physical) ~ Well-baby care ~ Well-child care ~ Adolescent well-care visits ~ Adult well-care visits ~ Screening for interpersonal and domestic violence ~ Counseling for sexually transmitted infections 	Covered at 100%
<ul style="list-style-type: none"> • Gynecological examination (breast exam and pelvic exam) 	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> • Digital prostate examination 	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> • Preventive hearing test 	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> • Comprehensive preventive vision examination 	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> • Mammogram to screen for breast cancer 	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> • Pap smear to screen for cervical cancer 	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> • Colonoscopy screening for colorectal cancer 	1 every five years then subject to deductible and coinsurance
<ul style="list-style-type: none"> • Sigmoidoscopy screening for colorectal cancer 	1 every five years then subject to deductible and coinsurance
<ul style="list-style-type: none"> • Other screenings for colorectal cancer ~ Fecal occult blood testing 	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> • Screening laboratory services Including, but are not limited to: basic metabolic panel, BRCA (1 & 2) testing, breast cancer genetic testing, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), pediatric lead poisoning screening, prostate specific antigen (PSA), and urinalysis. 	Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> • Bone mineral density (dexa scan) to screen for osteoporosis 	1 per calendar year then subject to deductible and coinsurance

Your Benefits	
<ul style="list-style-type: none"> • Chlamydia screening 	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> • Ultrasound for screening of an abdominal aortic aneurysm 	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> • Breast feeding support and counseling 	Covered at 100%
<ul style="list-style-type: none"> • Immunizations and vaccinations (including those needed for travel) 	Covered at 100%
Rehabilitative therapy	
<ul style="list-style-type: none"> • Occupational therapy 	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Physical therapy 	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Speech therapy 	Subject to deductible and coinsurance
Skilled nursing facility	Subject to deductible and coinsurance (Limited to 30 days per individual per confinement)
Surgical services	Subject to deductible and coinsurance
Temporomandibular joint disorders or TMJ non-surgical treatment	Subject to deductible and coinsurance (Limited to 4 physical/occupational visits for diagnosis of TMJ per year)
Transplant services	Subject to deductible and coinsurance
Vision examinations	Subject to deductible and coinsurance

Pharmacy	
<ul style="list-style-type: none"> • 100% coverage for preventive prescription drugs (not subject to deductible). Please refer to the Preventive Medication List for a list of covered products. • Up to 30 days worth of prescription drugs constitutes a 1-month supply. For most maintenance prescription drugs you may receive up to a 90-day supply and if applicable, 3 copayments and/or coinsurance and/or deductible will be assessed. • Pharmacy mail service may supply maintenance prescription drugs in a 90-day supply and if applicable, 2 copayments and/or coinsurance and/or deductible will be assessed. • 100% coverage for smoking cessation products, limited to 180 days per year. • The use of a specialty pharmacy may be required for select prescription drugs, as indicated in the Formulary Guide. 	<p>Subject to deductible.</p> <p>After deductible, the following copayments and/or coinsurance apply to covered prescription drugs until the maximum out-of-pocket is met.</p> <p>\$20 copayment per tier 1 prescription or refill.</p> <p>\$40 copayment per tier 2 prescription or refill.</p> <p>\$60 copayment per tier 3 prescription or refill.</p> <p>25% coinsurance per TIER 4 prescription or refill (specialty prescription drugs).</p> <p>Deductible, copayments and coinsurance may apply to the max out of pocket amounts.</p> <p>If the participant requests the brand name prescription drug where a generic is available, the participant must pay the applicable copayment/coinsurance plus the ancillary charge. The ancillary charge is the cost difference between the brand name prescription drug and the generic prescription drug. The ancillary charge will not count towards the prescription out-of-pocket limit.</p>

Dependent Coverage
<p>Dependent children are covered from birth through the end of the month they attain the age of 26.</p> <p>In addition, a child who meets the criteria above and is a full-time student as defined in the Certificate has an extension past age 26 IF the child was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was under 27 years of age and attending, on a full-time basis, an institution of higher learning. Such extension ends on the date described in the full-time student definition in the Certificate.</p>

Prior Authorization

The following services require you to obtain prior authorization before receiving the service. Your health care provider can start the prior authorization process by downloading a printable Prior Authorization Form at www.securityhealth.org/authorization or contact us at 1-800-548-1224.

Medical Services

- Abdominoplasty
- Air ambulance transport
- Amino Acid Formula
- Autologous Cultured Chondrocytes
- Cardiac catheterization for elective and outpatient procedures
- Clinical trials
- Cosmetic and reconstructive surgery
- Elective inpatient Admission including medical (acute and behavioral health) and surgical
- Electroconvulsive therapy (after 10 visits)
- Enteral feeding
- Technologies not commonly accepted as standard of care
- Femoro-acetabular surgery for hip impingement syndrome
- Gender reassignment
- Genetic testing
- Home health including but not limited to skilled nursing, physical therapy, occupational therapy, speech therapy
- Infuse bone graft
- Interventional pain management services
- Non-network provider request
- Non-emergent ambulance transport
- Outpatient procedure with site of service request as inpatient setting
- Outpatient therapy treatment (occupational therapy, physical therapy, speech therapy)
- Second opinion
- Skin substitutes
- Sleep Study
- Spinal cord stimulation
- Swing bed admission
- Transplants
- TMJ
- Vagus nerve stimulator

This list of medical services is not all inclusive. The most up-to-date medical services list requiring prior authorizations can be found on our website at www.securityhealth.org/authorization. You can also call our Customer Service Department at 1-844-293-9624 to find out what medical services require prior authorization.

Durable Medical Equipment

For most durable medical equipment (DME), you will need to work with your provider to receive prior authorization from Northwood at 1-866-532-1344.

The most up-to-date eligible durable medical equipment list can be found on our website at www.securityhealth.org/DME. You can also call our Customer Service Department at 1-800-472-2363 to find out what durable medical equipment is on the eligible list.

High-end imaging / Radiation oncology

For all high-end imaging and radiation oncology services, including by not limited to CT scans, PET scans, MRAs and MRIs, you will need to work with your provider to receive prior authorization from eviCore healthcare.

For high-end imaging

www.medsolutionsonline.com

Phone 1-888-693-3211

Fax an eviCore request form (available online) to 1-888-693-3210

For radiation oncology

www.carecorenational.com

Phone 1-888-444-6185

Skilled Nursing Facility Services

For the skilled nursing facility services listed, you will need to work with your provider to notify NaviHealth at 1-855-512-7002 (Fax 1-855-847-7243).

- Acute rehabilitation admission
- Long term acute care admission
- Skilled nursing facilities admission

Medical Benefit Drugs

Medical benefit drugs may require prior authorization. The most up-to-date medical benefit drug list can be found on our website at www.securityhealth.org/SpecialtyRx. Medical benefit drugs may be added or removed from this list quarterly on a calendar year basis. You can also call our Customer Service Department at 1-844-293-9624 to find out what medical benefit drugs require prior authorization. For medical benefit drug prior authorization, you will need to work with your provider to notify Magellan at 1-800-424-8243.

Home Infusions

Home infusion drugs may require prior authorization. The most up to date Home Infusion drug list can be found on our website at www.securityhealth.org/homeinfusion. Home infusion drugs may be added or removed from this list quarterly on a calendar year basis. You can also call our Customer Service Department at 1-844-293-9624 to find out what medical benefit drugs require prior authorization for home infusion.

Statement of Nondiscrimination

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

Limited English Proficiency Services
<p>ENGLISH: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-472-2363 (TTY:711).</p> <p>ATENCION: Si habla espanol, tiene a su disposicion servicios gratuitos de asistencia linguistica. Llame al 1-800-472-2363 (TTY: 711).</p> <p>LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-472-2363 (TTY: 711).</p>