Schedule of Benefits - HMO

Non-Represented - CITY OF MARSHFIELD
Benefit Year: January 1st through December 31st
Effective Date: 01/01/2013

SecurityHealth Plan®
www.securityhealth.org

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	$500 per individual $1,500 per family
Coinsurance	10% of the next $5,000 per individual $15,000 per family
Annual out of pocket (Deductible & coinsurance)	$1,000 per individual $3,000 per family
Lifetime maximum benefit limit	Unlimited

Your Benefits	
Ambulance services	Subject to deductible and coinsurance
Anesthesia services	Subject to deductible and coinsurance
Autism spectrum disorder treatment	Subject to deductible and coinsurance
Chiropractic services	Subject to deductible and coinsurance
Durable medical equipment and medical supplies (Including insulin pump and supplies)	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	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	Subject to deductible and coinsurance
Maternity services	
• **Hospital services**	Subject to deductible and coinsurance
• **Physician services**	Subject to deductible and coinsurance

Your Benefits	
Mental health services	
• **Inpatient care**	Subject to deductible and coinsurance
• **Outpatient care**	6 days covered at 100% per calendar year then subject to deductible and coinsurance
• **Transitional care**	6 days covered at 100% per calendar year then subject to deductible and coinsurance
Office visits	Subject to deductible and coinsurance (Preventive exams covered at 100%)
Outpatient laboratory services	Subject to deductible and coinsurance
Outpatient radiology services	Subject to deductible and coinsurance
Outpatient therapy services	
• **Occupational therapy**	Subject to deductible and coinsurance
• **Physical therapy**	Subject to deductible and coinsurance
• **Speech therapy**	Subject to deductible and coinsurance
Physician services	
• **Hospital services**	Subject to deductible and coinsurance
• **Other services in an office**	Subject to deductible and coinsurance (Preventive immunizations covered at 100%)

Your Benefits	
Preventive benefit Please refer to Security Health Plan's Preventive Service Guidelines at www.securityhealth.org for service frequency recommendations.	
• **Comprehensive physical examination** (complete physical) ~ Well-baby care ~ Well-child care ~ Adolescent well-care ~ Adult well-care	Covered at 100%
• **Gynecological examination for women** (breast exam and pelvic exam)	1 per calendar year then subject to deductible and coinsurance
• **Digital prostate examination for men**	1 per calendar year then subject to deductible and coinsurance
• **Preventive hearing test**	1 per calendar year then subject to deductible and coinsurance
• **Comprehensive preventive vision examination**	1 per calendar year then subject to deductible and coinsurance
• **Mammogram to screen for breast cancer**	1 per calendar year then subject to deductible and coinsurance
• **Pap smear to screen for cervical cancer**	1 per calendar year then subject to deductible and coinsurance
• **Colonoscopy screening for colorectal cancer**	1 every two years then subject to deductible and coinsurance
• **Other screenings for colorectal cancer** ~ Sigmoidoscopy ~ Double contrast barium enema ~ Fecal occult blood testing	1 per calendar year then subject to deductible and coinsurance
• **Screening laboratory services** Including, but are not limited to: basic metabolic panel, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), prostate specific antigen (PSA), and urinalysis.	Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance
• **Bone mineral density (dexa scan) to screen for osteoporosis in women**	1 per calendar year then subject to deductible and coinsurance
• **Chlamydia screening for women**	1 per calendar year then subject to deductible and coinsurance
• **Ultrasound for screen of an abdominal aortic aneurysm for men**	1 per calendar year then subject to deductible and coinsurance

Your Benefits	
• **Immunizations and vaccinations** (including those needed for travel)	Covered at 100%
Skilled nursing facility	Subject to deductible and coinsurance (Limited to 30 days per individual per confinement)
Substance abuse services	
• **Inpatient care**	Subject to deductible and coinsurance
• **Outpatient care**	6 days covered at 100% per calendar year then subject to deductible and coinsurance
• **Transitional care**	15 days covered at 100% per calendar year then subject to deductible and coinsurance
Surgical services	Subject to deductible and coinsurance
Temporomandibular joint disorders or TMJ non-surgical treatment	Subject to deductible and coinsurance (Limited to $1,250 maximum per individual per calendar year)
Transplant services	Subject to deductible and coinsurance
Vision examinations	Subject to deductible and coinsurance

Pharmacy	
• Up to 30 days worth of medication constitutes a 1-month supply. For most maintenance medications 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 medications in a 90-day supply and if applicable, 2 copayments and/or coinsurance and/or deductible will be assessed. • Copayments and/or coinsurance and/or deductible will be assessed on oral anti-diabetic medications. • 100% coverage for tier 1 and tier 2 insulin and diabetic testing supplies. (Not subject to deductible, if applicable.) • Insulin and diabetic testing supplies not listed on tier 1 or tier 2 of the Formulary Guide will require medical exception review from the Security Health Plan Pharmacy Services Department. (This does not include insulin pumps and related supplies. Please refer to the durable medical equipment section of the Schedule of Benefits for coverage.) • 100% coverage for smoking cessation products, limited to 180 days per calendar year, as indicated in the Formulary Guide. • Limited coverage for sexual dysfunction medications (e. g. Viagra®), as indicated in the Formulary Guide. • Over-the-counter (OTC) medications are generally excluded; however, coverage may be provided for selected OTC medications with a prescription authorization, as indicated in the Formulary Guide. • The use of a specialty pharmacy may be required for select medications, as indicated in the Formulary Guide.	Tier 1 drugs-member pays the greater of $10 or 20% of the cost of prescriptions to a maximum of $15 per prescription. Tier 2 drugs-member pays the greater of $20 or 30% of the cost of prescriptions to a maximum of $75 per prescription. Tier 3 drugs-member pays the greater of $40 or 50% of the cost of prescriptions with no maximum. Maximum out-of-pocket (copay and coinsurance) $1,250 per individual per calendar year. Maximum out-of-pocket (copay and coinsurance) $2,500 per family per calendar year.

Dependent Coverage
Dependent children are covered from birth through the end of the month they attain the age of 26. 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.

Waiting period for pre-existing condition
• 0 months for new enrollees • 18 months for late enrollees Does not apply to children under 19 years of age.

SecurityHealth Plan

CITY OF MARSHFIELD,Non-Represented

Coverage Period:
01/01/2013 - 12/31/2013

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.securityhealth.org or by calling 1-800-472-2363.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$500 per individual $1,500 per family If your employer has a HRA, see your employer for details.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. Does not apply to preventive care.
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. $1,000 per individual $3,000 per family	The **out-of-pocket** 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?	Copayments if applicable, premiums, 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. See www.securityhealth.org or call 1-800-472-2363 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**.
Do I need a referral to see a specialist?	No.	You may see any specialist listed in our Provider Directory without a referral, unless you have POS or indemnity coverage which will enable you to see any specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-472-2363 or visit us at www.securityhealth.org.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-472-2363 to request a copy.

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

- 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 preferred 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	Coinsurance applies after deductible is met
	Specialist visit	10% coinsurance	Not covered	Coinsurance applies after deductible is met
	Other practitioner office visit	10% coinsurance	Not covered	Acupuncture Coinsurance applies after deductible is met
	Preventive care/screening/immunization	Refer to your Schedule of Benefits for specific frequency limits	Not covered	Generally, preventive services are covered at 100%. Certain preventive services may be limited to coverage for a certain number of visits per calendar year. Please refer to your policy plan documents for more specific information.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	Coinsurance applies after deductible is met
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	Coinsurance applies after deductible is met

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

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.securityhealth.org	Tier 1	Tier 1 drugs-member pays the greater of $10 or 20% of the cost of prescriptions to a maximum of $15 per prescription.	Not covered	Provider means pharmacy for purposes of this section. Most pharmacies nationwide are included in the provider network (more than 50,000 pharmacies). You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have prior authorization requirements. You may be required to use a lower-cost drug(s) prior to coverage being available for certain prescribed drugs.
	Tier 2	Tier 2 drugs-member pays the greater of $20 or 30% of the cost of prescriptions to a maximum of $75 per prescription.	Not covered	
	Tier 3	Tier 3 drugs-member pays the greater of $40 or 50% of the cost of prescriptions with no maximum.	Not covered	
	Specialty drugs	Specialty drugs can be found in all 3 tiers. Refer to your Formulary for specific tier information.	Not covered	

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

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	This service does not include emergency room Coinsurance applies after deductible is met
	Physician/surgeon fees	10% coinsurance	Not covered	Coinsurance applies after deductible is met
If you need immediate medical attention	Emergency room services	10% coinsurance	Not covered	Deductible and copays may apply for services performed in the ER (such as labs, X-rays) ER facility copay does not apply towards out-of-pocket limit
	Emergency medical transportation	10% coinsurance	Not covered	Coinsurance applies after deductible is met
	Urgent care	10% coinsurance	Not covered	Coinsurance applies after deductible is met
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	Coinsurance applies after deductible is met
	Physician/surgeon fee	10% coinsurance	Not covered	Coinsurance applies after deductible is met

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

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 mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	6 days covered at 100% per calendar year then subject to deductible and coinsurance	Not covered	---none---
	Mental/Behavioral health inpatient services	10% coinsurance	Not covered	Coinsurance applies after deductible is met
	Substance use disorder outpatient services	6 days covered at 100% per calendar year then subject to deductible and coinsurance	Not covered	---none---
	Substance use disorder inpatient services	10% coinsurance	Not covered	Coinsurance applies after deductible is met
If you are pregnant	Prenatal and postnatal care	10% coinsurance	Not covered	Coinsurance applies after deductible is met
	Delivery and all inpatient services	10% coinsurance	Not covered	Coinsurance applies after deductible is met

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

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 help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	Limited to 40 visits per individual per calendar year Coinsurance applies after deductible is met
	Rehabilitation services	10% coinsurance	Not covered	Coinsurance applies after deductible is met
	Habilitation services	Not covered	Not covered	Habilitation services are generally not covered; please refer to your schedule of benefits for specifics.
	Skilled nursing care	10% coinsurance	Not covered	Limited to 30 days per individual per confinement Coinsurance applies after deductible is met
	Durable medical equipment	10% coinsurance	Not covered	Coinsurance applies after deductible is met
	Hospice services	10% coinsurance	Not covered	Coinsurance applies after deductible is met
If your child needs dental or eye care	Eye exam	10% coinsurance	Not covered	Coinsurance applies after deductible is met
	Glasses	Not covered	Not covered	Glasses are generally not covered; please refer to your plan documents for specifics.
	Dental check-up	Not covered	Not covered	Dental check-up services are generally not covered; please refer to your plan documents for specifics.

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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	• Cosmetic Surgery	• Dental care (Adult)
• Hearing aids	• Infertility treatment	• Long-term care
• Routine foot care (except for certain conditions)	• Weight loss programs	• Non-emergency care when traveling outside the U.S.
• 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.)		
• Bariatric surgery(Requires plan approval)	• Chiropractic care	• Routine eye care (Adult)

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 1-800-472-2363. 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 Appeal 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:

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

- Security Health Plan at 1-715-221-9555 or 1-800-472-2363. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. In Wisconsin, you may contact the Office of the Commissioner of Insurance (OCI) at (608) 266-3585, or (800) 236-8517.

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

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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** $6,540.00
- **Patient pays** $1,000.00

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	$500.00
Copays	$0.00
Coinsurance	$500.00
Limits or exclusions	$0.00
Total	**$1,000.00**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,980.00
- **Patient pays** $420.00

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	$420.00
Copays	$0.00
Coinsurance	$0.00
Limits or exclusions	$0.00
Total	**$420.00**

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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