Schedule of Benefits - HMO Central
Group - EAU CLAIRE AREA SCHOOL DISTRICT
Benefit Year: July 1st through June 30th
Effective Date: 07/01/2017

SecurityHealth Plan℠

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.**

No deductible, co-pay or co-insurance for services rendered at the Clairemont Center.

Your Responsibilities	
Deductible	$3,000 per individual $6,000 per family
Office visit copayment	$25 copayment per office visit (Copayment does not apply to preventive exams)
Emergency room facility copayment (Waived if admitted to the hospital as an inpatient)	$250 copayment per visit
Annual out of pocket (Deductible & copayments)	$3,000 per individual $6,000 per family
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
Anesthesia services	Subject to deductible
Chiropractic services	$25 copayment per office visit (Applies for both chiropractic office visits and manipulation services received)
Durable medical equipment and medical supplies (Including insulin pump and supplies)	Subject to deductible
Hearing examinations	Subject to deductible
Home health care	Subject to deductible (Limited to 40 visits per individual per calendar year)
Hospice care	Subject to deductible

Schedule of Benefits - HMO Central
Group - EAU CLAIRE AREA SCHOOL DISTRICT
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Your Benefits	
Hospital emergency room services	
• **Emergency room facility** (Copayment waived if admitted to hospital as inpatient)	$250 copayment per visit
• **Other emergency room services**	Subject to deductible
Hospital inpatient services (Including semi-private or special care room, operating room, ancillary services and supplies)	Subject to deductible
Hospital outpatient and surgical center services	Subject to deductible
Maternity services	
• **Hospital services**	Subject to deductible
• **Physician services**	Subject to deductible
Mental health services	
• **Inpatient care**	Subject to deductible
• **Outpatient care**	6 days covered at 100% per calendar year then subject to deductible
• **Transitional care**	6 days covered at 100% per calendar year then subject to deductible
Office visits	$25 copayment per office visit (Copayment does not apply to preventive exams)
Outpatient laboratory services	Covered at 100%
Outpatient radiology services	
• **CT scans, MRIs and PET scans**	Subject to deductible
• **Radiology services (except CT scans, MRIs and PET scans)**	Covered at 100%
Outpatient therapy services	
• **Occupational therapy**	$25 copayment per visit
• **Physical therapy**	$25 copayment per visit
• **Speech therapy**	$25 copayment per visit

Schedule of Benefits - HMO Central
Group - EAU CLAIRE AREA SCHOOL DISTRICT
Benefit Year: July 1st through June 30th
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Your Benefits	
Physician services	
• **Hospital services**	Subject to deductible
• **Other services in an office**	Subject to deductible (Preventive immunizations covered at 100%)
Preventive benefit Please refer to the Security Health Plan wellness guide at www.securityhealth.org/preventive for recommendations on frequency of preventive services. • Routine preventive examination • Gynecological examination (breast exam and pelvic exam) • Digital prostate examination • Preventive hearing test • Preventive vision examination • Mammograms to screen for breast cancer • Pap Smears to screen for cervical cancer • Sigmoidoscopy, colonoscopy, and/or fecal occult blood testing to screen for colon or colorectal cancer • Screening laboratory services, including, but are not limited to: basic metabolic panel, 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 • Bone mineral density (dexa scan) for osteoporosis screening • Chlamydia screening • Ultrasound for screen of an abdominal aortic aneurysm • Breast feeding support and counseling • Immunizations and vaccinations (including those needed for travel)	Covered at 100%
Skilled nursing facility	Subject to deductible (Limited to 30 days per individual per confinement)
Substance abuse services	
• **Inpatient care**	Subject to deductible
• **Outpatient care**	6 days covered at 100% per calendar year then subject to deductible
• **Transitional care**	15 days covered at 100% per calendar year then subject to deductible
Surgical services	Subject to deductible

Your Benefits	
Temporomandibular joint disorders or TMJ non-surgical treatment	Subject to deductible
Transplant services	Subject to deductible
Vision examinations	Subject to deductible

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 benefit year, as indicated in the Formulary Guide. • Limited coverage for sexual dysfunction medications, 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.	$0 copayment per tier 1 prescription or refill. $25 copayment per tier 2 prescription or refill. $50 copayment per tier 3 prescription or refill. Deductible, copayments and coinsurance may apply to the max out of pocket amounts. Benefit year - July 1st thru June 30th If the participant requests the brand name product for a medication 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 product and the generic product. The ancillary charge will not count towards the prescription out-of-pocket limit.

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.

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/priorauthorization or contact us at 1-800-548-1224.

Medical Services

- Abdominoplasty
- Air ambulance transport
- Amino Acid Formula
- Autologous Cultured Chondrocytes
- Clinical trials
- Cosmetic and reconstructive surgery
- Elective inpatient Admission including medical (acute and behavioral health) and surgical
- Enteral feeding
- Experimental or investigational services
- Fecal transplant
- Gender reassignment
- Genetic testing
- Hearing aids for members over 18 years of age
- Home health including but not limited to skilled nursing, physical therapy, occupational therapy, speech therapy
- Hospice
- Infuse bone graft
- Intrastromal corneal ring segments
- Lung volume reduction surgery
- Non-affiliate provider request
- Non-emergent ambulance transport
- Office procedure with site of service request other than in an office setting
- Oral appliance for obstructive sleep apnea
- Outpatient procedure with site of service request as inpatient setting
- Outpatient therapy treatment (occupational therapy, physical therapy, speech therapy)
- Second opinion
- Spinal cord stimulation
- Swing bed admission
- Transplants
- TMJ
- Elective outpatient procedures such as, but not limited to: carpal tunnel surgery, knee arthroscopy, back surgeries at all levels

Medical Pharmacy

- Antibiotic - Antiviral Intravenous Infusion
- Antidiarrheals
- Antiemetics
- Antineoplastics
- Biological Response Modifiers
- Bone resorption Inhibitors
- Botulinum toxin
- Colony Stimulating factors
- Home Infusion - Chemotherapy
- Hormone modifiers
- Hyaluronic acid
- Immunoglobulins
- Immunosuppressives
- Intravenous hydration

Prior Authorization

- Intravenous Immunoglobulin - Subcutaneous Immunoglobulin Infusion
- IV Infusion Therapy Authorization Request: TPN and hydration
- intravitreal macular degeneration agents
- Parathyroid hormones
- Parenteral Nutrition Home Infusion
- Prostaglandins
- Respiratory agents
- Synagis
- Total Parenteral Nutrition (TPN)

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.

Shared Decision Making

Shared decision-making is a required step for some prior authorizations. After the prior authorization form has been submitted, members will be required to complete shared decision making prior to receiving the following surgeries or specialty consults.

- Carpal tunnel specialty consult
- Chronic hip pain specialty consult
- Chronic knee pain specialty consult
- Hysterectomy with fibroid diagnosis surgery
- Low back pain specialty consult

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

High end imaging / Radiation oncology

For all high-end imaging and radiation oncology services, you will need to work with your provider to receive prior authorization from eviCore healthcare.

<u>For high end imaging</u>
- www.medsolutionsonline.com
- Phone 1-888-693-3211
- Fax an eviCore request form (available online) to 1-888-693-3210

<u>For radiation oncology</u>
- www.carecorenational.com
- Phone 1-888-444-6185

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, age, disability, or sex.

Limited English Proficiency Services

ATENCION: si habla espanol, tiene a su disposicion servicios gratuitos de asistencia linguistica. Llame al 1-800-472-2363 (TTY: 711).

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).

Schedule of Benefits - Open Access

Group - EAU CLAIRE AREA SCHOOL DISTRICT
Benefit Year: July 1st through June 30th
Effective Date: 07/01/2017

SecurityHealth Plan℠

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

This Schedule shows how much you pay for certain types of services. It shows 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 along with your Certificate for details about your coverage.** Benefits are based on the benefit year shown above.

Reimbursement is limited for out-of-network benefits to the reasonable and customary charges for cost-effective services. It is also subject to applicable deductible, coinsurance and copayment amounts. *Security Health Plan pays non-network providers* based on our Usual, Customary, and Reasonable (UCR) fee schedule. If a charge exceeds our reasonable and customary fee limit, we may reimburse less than the billed charge. In this case, the member is responsible for any amount charged in excess of such fees. The member is also responsible for applicable deductible, coinsurance and copayment amounts. Any amount not covered by the UCR fee schedule and paid by the member does not count toward the maximum out-of-pocket limit for the plan.

Network Tier 1 ~ Security Health Plan primary network
Network Tier 2 ~ Non-network providers in Barron, Chippewa, Dunn, Eau Claire and Trempealeau
Network Tier 3 ~ All other out-of-area and non-network licensed providers
Clairemont Center ~No deductible, copayment or coinsurance for services rendered at the Clairemont Center

Your Responsibilities	Tier 1 - In-Network	Tier 2 - Out-of-Network	Tier 3 - Out-of-Network
Deductible	$3,000 per individual $6,000 per family	$3,000 per individual $6,000 per family	$6,000 per individual $12,000 per family
Coinsurance	Covered services paid at 100% after deductible.	Covered services paid at 100% after deductible.	20% of the next $5,000 per individual $10,000 per family
Office visit copayment	$25 copayment per office visit (Copayment does not apply to preventive exams)	$25 copayment per office visit (Copayment does not apply to preventive exams)	Subject to deductible and coinsurance
Emergency room facility copayment (Waived if admitted to the hospital as an inpatient)	$250 copayment per visit	$250 copayment per visit	$250 copayment per visit

Schedule of Benefits - Open Access
Group - EAU CLAIRE AREA SCHOOL DISTRICT
Benefit Year: July 1st through June 30th
Effective Date: 07/01/2017

SecurityHealth Plan℠

Your Responsibilities	Tier 1 - In-Network	Tier 2 - Out-of-Network	Tier 3 - Out-of-Network
Annual out of pocket (Deductible, coinsurance & copayments) In-network amounts accumulate to the out-of-network, out-of-pocket maximum. Out-of-network amounts accumulate to the in-network, out-of-pocket maximum.	$3,000 per individual $6,000 per family	$3,000 per individual $6,000 per family	$7,000 per individual $14,000 per family
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.	Such coverage shall be provided at the in network level of benefits.	Such coverage shall be provided at the in network level of benefits.

Your Benefits	Tier 1 - In-Network	Tier 2 - Out-of-Network	Tier 3 - Out-of-Network
Ambulance services	Subject to deductible	Subject to deductible	Subject to deductible and coinsurance
Anesthesia services	Subject to deductible	Subject to deductible	Subject to deductible and coinsurance
Chiropractic services	$25 copayment per office visit (Applies for both chiropractic office visits and manipulation services received)	$25 copayment per office visit (Applies for both chiropractic office visits and manipulation services received)	Subject to deductible and coinsurance
Durable medical equipment and medical supplies (Including insulin pump and supplies)	Subject to deductible	Subject to deductible	Subject to deductible and coinsurance
Hearing examinations	Subject to deductible	Subject to deductible	Subject to deductible and coinsurance

Your Benefits	Tier 1 - In-Network	Tier 2 - Out-of-Network	Tier 3 - Out-of-Network
Home health care	Subject to deductible (Limited to 40 visits per individual per calendar year)	Subject to deductible (Limited to 40 visits per individual per calendar year)	Subject to deductible and coinsurance (Limited to 40 visits per individual per calendar year)
Hospice care	Subject to deductible	Subject to deductible	Subject to deductible and coinsurance
Hospital emergency room services			
• **Emergency room facility** (Copayment waived if admitted to hospital as inpatient)	$250 copayment per visit	$250 copayment per visit	$250 copayment per visit
• **Other emergency room services**	Subject to deductible	Subject to deductible	Subject to deductible and coinsurance
Hospital inpatient services (Including semi-private or special care room, operating room, ancillary services and supplies)	Subject to deductible	Subject to deductible	Subject to deductible and coinsurance
Hospital outpatient and surgical center services	Subject to deductible	Subject to deductible	Subject to deductible and coinsurance
Maternity services			
• **Hospital services**	Subject to deductible	Subject to deductible	Subject to deductible and coinsurance
• **Physician services**	Subject to deductible	Subject to deductible	Subject to deductible and coinsurance

Your Benefits	Tier 1 - In-Network	Tier 2 - Out-of-Network	Tier 3 - Out-of-Network
Mental health services			
• **Inpatient care**	Subject to deductible	Subject to deductible	Subject to deductible and coinsurance
• **Outpatient care**	6 days covered at 100% per calendar year then subject to deductible	6 days covered at 100% per calendar year then subject to deductible	Subject to deductible and coinsurance
• **Transitional care**	6 days covered at 100% per calendar year then subject to deductible	6 days covered at 100% per calendar year then subject to deductible	Subject to deductible and coinsurance
Office visits	$25 copayment per office visit (Copayment does not apply to preventive exams)	$25 copayment per office visit (Copayment does not apply to preventive exams)	Subject to deductible and coinsurance
Outpatient laboratory services	Covered at 100%	Covered at 100%	Subject to deductible and coinsurance
Outpatient radiology services			
• **CT scans, MRIs and PET scans**	Subject to deductible	Subject to deductible	Subject to deductible and coinsurance
• **Radiology services (except CT scans, MRIs and PET scans)**	Covered at 100%	Covered at 100%	Subject to deductible and coinsurance

Your Benefits	Tier 1 - In-Network	Tier 2 - Out-of-Network	Tier 3 - Out-of-Network
Outpatient therapy services			
• **Occupational therapy**	$25 copayment per visit	$25 copayment per visit	Subject to deductible and coinsurance
• **Physical therapy**	$25 copayment per visit	$25 copayment per visit	Subject to deductible and coinsurance
• **Speech therapy**	$25 copayment per visit	$25 copayment per visit	Subject to deductible and coinsurance
Physician services			
• **Hospital services**	Subject to deductible	Subject to deductible	Subject to deductible and coinsurance
• **Other services in an office**	Subject to deductible (Preventive immunizations covered at 100%)	Subject to deductible (Preventive immunizations covered at 100%)	Subject to deductible and coinsurance

Your Benefits	Tier 1 - In-Network	Tier 2 - Out-of-Network	Tier 3 - Out-of-Network
Preventive benefit Please refer to the Security Health Plan wellness guide at www.securityhealth.org/preventive for recommendations on frequency of preventive services. • Routine preventive examination • Gynecological examination (breast exam and pelvic exam) • Digital prostate examination • Preventive hearing test • Preventive vision examination • Mammograms to screen for breast cancer • Pap Smears to screen for cervical cancer • Sigmoidoscopy, colonoscopy, and/or fecal occult blood testing to screen for colon or colorectal cancer • Screening laboratory services, including, but are not limited to: basic metabolic panel, 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 • Bone mineral density (dexa scan) for osteoporosis screening • Chlamydia screening • Ultrasound for screen of an abdominal aortic aneurysm • Breast feeding support and counseling • Immunizations and vaccinations (including those needed for travel)	Covered at 100%	Covered at 100%	Subject to deductible and coinsurance
Skilled nursing facility	Subject to deductible (Limited to 30 days per individual per confinement)	Subject to deductible (Limited to 30 days per individual per confinement)	Subject to deductible and coinsurance (Limited to 30 days per individual per confinement)

Your Benefits	Tier 1 - In-Network	Tier 2 - Out-of-Network	Tier 3 - Out-of-Network
Substance abuse services			
• **Inpatient care**	Subject to deductible	Subject to deductible	Subject to deductible and coinsurance
• **Outpatient care**	6 days covered at 100% per calendar year then subject to deductible	6 days covered at 100% per calendar year then subject to deductible	Subject to deductible and coinsurance
• **Transitional care**	15 days covered at 100% per calendar year then subject to deductible	15 days covered at 100% per calendar year then subject to deductible	Subject to deductible and coinsurance
Surgical services	Subject to deductible	Subject to deductible	Subject to deductible and coinsurance
Temporomandibular joint disorders or TMJ non-surgical treatment	Subject to deductible	Subject to deductible	Subject to deductible and coinsurance
Transplant services	Subject to deductible	Subject to deductible	Not covered
Vision examinations	Subject to deductible	Subject to deductible	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 benefit year, as indicated in the Formulary Guide. • Limited coverage for sexual dysfunction medications, 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.	$0 copayment per tier 1 prescription or refill. $25 copayment per tier 2 prescription or refill. $50 copayment per tier 3 prescription or refill. Deductible, copayments and coinsurance may apply to the max out of pocket amounts. Benefit year - July 1st thru June 30th If the participant requests the brand name product for a medication 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 product and the generic product. The ancillary charge will not count towards the prescription out-of-pocket limit.

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.

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/priorauthorization or contact us at 1-800-548-1224.

Medical Services

- Abdominoplasty
- Air ambulance transport
- Amino Acid Formula
- Autologous Cultured Chondrocytes
- Clinical trials
- Cosmetic and reconstructive surgery
- Elective inpatient Admission including medical (acute and behavioral health) and surgical
- Enteral feeding
- Experimental or investigational services
- Fecal transplant
- Gender reassignment
- Genetic testing
- Hearing aids for members over 18 years of age
- Home health including but not limited to skilled nursing, physical therapy, occupational therapy, speech therapy
- Hospice
- Infuse bone graft
- Intrastromal corneal ring segments
- Lung volume reduction surgery
- Non-affiliate provider request
- Non-emergent ambulance transport
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- Outpatient procedure with site of service request as inpatient setting
- Outpatient therapy treatment (occupational therapy, physical therapy, speech therapy)
- Second opinion
- Spinal cord stimulation
- Swing bed admission
- Transplants
- TMJ
- Elective outpatient procedures such as, but not limited to: carpal tunnel surgery, knee arthroscopy, back surgeries at all levels

Medical Pharmacy

Prior Authorization

- Antibiotic - Antiviral Intravenous Infusion
- Antidiarrheals
- Antiemetics
- Antineoplastics
- Biological Response Modifiers
- Bone resorption Inhibitors
- Botulinum toxin
- Colony Stimulating factors
- Home Infusion - Chemotherapy
- Hormone modifiers
- Hyaluronic acid
- Immunoglobulins
- Immunosuppressives
- Intravenous hydration
- Intravenous Immunoglobulin - Subcutaneous Immunoglobulin Infusion
- IV Infusion Therapy Authorization Request: TPN and hydration
- intravitreal macular degeneration agents
- Parathyroid hormones
- Parenteral Nutrition Home Infusion
- Prostaglandins
- Respiratory agents
- Synagis
- Total Parenteral Nutrition (TPN)

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.

Shared Decision Making

Shared decision-making is a required step for some prior authorizations. After the prior authorization form has been submitted, members will be required to complete shared decision making prior to receiving the following surgeries or specialty consults.

- Carpal tunnel specialty consult
- Chronic hip pain specialty consult
- Chronic knee pain specialty consult
- Hysterectomy with fibroid diagnosis surgery
- Low back pain specialty consult

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

High end imaging / Radiation oncology

For all high-end imaging and radiation oncology services, 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

SecurityHealth Plan℠

Statement of Nondiscrimination

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Limited English Proficiency Services

ATENCION: si habla espanol, tiene a su disposicion servicios gratuitos de asistencia linguistica. Llame al 1-800-472-2363 (TTY: 711).

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).