Schedule of Benefits - Point of Service Central

Group 501546 - GRANTON AREA SCHOOL DISTRICT
Benefit Year: January 1st through December 31st
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.

Security Health Plan pays non-network providers based on our Usual, Customary and Reasonable (UCR) fee schedule, subject to applicable deductible, coinsurance and copayment amounts. If a charge exceeds our reasonable and customary fee limit, we may reimburse less than the billed charge and the member is responsible for any amount charged in excess of such fees, as well as 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.

Your Responsibilities	In network	Out of network
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.	$1,500 per individual $3,000 per family The individual deductible does not apply under a family plan. One or more members of the family must meet the family deductible before benefits will be paid.	$3,000 per individual $6,000 per family The individual deductible does not apply under a family plan. One or more members of the family must meet the family deductible before benefits will be paid.
Coinsurance	Covered services paid at 100% after deductible.	30% of the next $10,000 per individual $20,000 per family
Annual out of pocket (Deductible & coinsurance) 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.	$1,500 per individual $3,000 per family Only the family limit above applies to a family plan.	$6,000 per individual $12,000 per family Only the family limit above applies to a family plan.
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.

Your Benefits	In network	Out of network
Ambulance services	Subject to deductible	Subject to deductible and coinsurance
Anesthesia services	Subject to deductible	Subject to deductible and coinsurance
Chiropractic services	Subject to deductible	Subject to deductible and coinsurance

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Your Benefits	In network	Out of network
Durable medical equipment and medical supplies (Including insulin pump and supplies)	Subject to deductible	Subject to deductible and coinsurance
Hearing examinations	Subject to deductible	Subject to deductible and coinsurance
Home health care	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 and coinsurance
Hospital emergency room services	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 and coinsurance
Hospital outpatient and surgical center services (Not including emergency room)	Subject to deductible	Subject to deductible and coinsurance
Maternity services		
• **Hospital services**	Subject to deductible	Subject to deductible and coinsurance
• **Physician services**	Subject to deductible	Subject to deductible and coinsurance
Mental health and substance abuse services		
• **Inpatient care**	Subject to deductible	Subject to deductible and coinsurance
• **Outpatient care**	Subject to deductible	Subject to deductible and coinsurance
• **Transitional care**	Subject to deductible	Subject to deductible and coinsurance
Office visits	Subject to deductible (Preventive exams covered at 100%)	Subject to deductible and coinsurance
Outpatient laboratory services	Subject to deductible	Subject to deductible and coinsurance
Outpatient radiology services	Subject to deductible	Subject to deductible and coinsurance

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Your Benefits	In network	Out of network
Outpatient therapy services		
• **Occupational therapy**	Subject to deductible	Subject to deductible and coinsurance
• **Physical therapy**	Subject to deductible	Subject to deductible and coinsurance
• **Speech therapy**	Subject to deductible	Subject to deductible and coinsurance
Physician services		
• **Hospital services**	Subject to deductible	Subject to deductible and coinsurance
• **Other services in an office**	Subject to deductible (Preventive immunizations covered at 100%)	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Preventive benefit Please refer to Security Health Plan's Preventive Service Guidelines at www.securityhealth.org/preventive for service frequency recommendations.		
• **Comprehensive physical examination** (complete physical) ~ Well-baby care ~ Well-child care ~ Adolescent well-care ~ Adult well-care	Covered at 100%	Subject to deductible and coinsurance
• **Gynecological examination** (breast exam and pelvic exam)	1 per calendar year then subject to deductible	Subject to deductible and coinsurance
• **Digital prostate examination**	1 per calendar year then subject to deductible	Subject to deductible and coinsurance
• **Preventive hearing test**	1 per calendar year then subject to deductible	Subject to deductible and coinsurance
• **Comprehensive preventive vision examination**	1 per calendar year then subject to deductible	Subject to deductible and coinsurance
• **Mammogram to screen for breast cancer**	1 per calendar year then subject to deductible	Subject to deductible and coinsurance
• **Pap smear to screen for cervical cancer**	1 per calendar year then subject to deductible	Subject to deductible and coinsurance
• **Colonoscopy screening for colorectal cancer**	1 every two years then subject to deductible	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	Subject to deductible and coinsurance
• **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.	Each laboratory service covered at 1 per calendar year then subject to deductible	Subject to deductible and coinsurance
• **Bone mineral density (dexa scan) to screen for osteoporosis**	1 per calendar year then subject to deductible	Subject to deductible and coinsurance
• **Chlamydia screening**	1 per calendar year then subject to deductible	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
• **Ultrasound for screen of an abdominal aortic aneurysm**	1 per calendar year then subject to deductible	Subject to deductible and coinsurance
• **Breast feeding support and counseling**	Covered at 100%	Subject to deductible and coinsurance
• **Immunizations and vaccinations** (including those needed for travel)	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 and coinsurance (Limited to 30 days per individual per confinement)
Surgical services	Subject to deductible	Subject to deductible and coinsurance
Temporomandibular joint disorders or TMJ non-surgical treatment	Subject to deductible	Subject to deductible and coinsurance
Transplant services	Subject to deductible	Not covered
Vision examinations	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, 1 copayment and/or coinsurance and/or deductible will be assessed. • Insulin and diabetic testing supplies are subject to deductible and maximum out-of-pocket amounts, if applicable. (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, 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.	Subject to the $1,500 individual deductible and $3,000 family deductible per calendar year. 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

Prior Authorization
• 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

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).