SecurityHealth Plan
Security Administrative Services

City of Stevens Point
Group Number: 210396
Effective Date: January 1, 2021
Benefit Year: January-December
Non-Grandfathered Plan

SCHEDULE OF BENEFITS
HDHP
(All active employees EXCEPT Transit Union)

This schedule is provided as a convenience only and is not all-inclusive. Important information is contained in your Summary Plan Description. Please note all Out-of-Network Provider charges are subject to usual, customary and reasonable fees. It is strongly recommended that you read the entire summary plan description to ensure a complete understanding of the Plan provisions. You may also contact the third party administrator or the Plan Administrator for assistance.

Your Responsibilities	In network	Out of network
Deductible*	$1,500 individual $3,000 family	$2,500 individual $5,000 family
Coinsurance*	10%	30%
Annual Coinsurance Limit	$1,000 individual $2,000 family	$2,500 individual $5,000 family
Annual Deductible and Coinsurance Limit	$2,500 individual $5,000 family	$5,000 individual $10,000 family
Out of Pocket Maximum Deductible, coinsurance, and medical 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.	$6,400 individual $12,900 family The individual in-network out of pocket is limited to $6,400 when enrolled in a family plan.	$8,900 individual $17,900 family
* The family deductible and coinsurance can be satisfied by **one** family member. The deductible must be satisfied before the plan will make any payment for services (other than preventive services).		

Your Benefits	In network	Out of network
Ambulance services	Subject to deductible and coinsurance	Subject to in-network deductible and coinsurance
Anesthesia services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Autism services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Care My Way	Three services covered at 100%, then subject to deductible and coinsurance.	Not Applicable
Chiropractic Services Includes chiropractic office visit. No coverage for maintenance therapy.	Subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Durable medical equipment and medical supplies Including insulin pump and supplies	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hearing aids and implantable hearing devices Limited to children up to age 18	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hearing examinations	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Home health care Limited to 100 visits per 12 month period	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hospice care		
• **Home hospice** Limited to 80 visits per 6 month period	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Inpatient hospice** Limited to 30 days per calendar year	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hospital emergency room services**		
• **Emergency room facility**	Subject to deductible until satisfied, then subject to 10% coinsurance after $100 copayment	Subject to in-network deductible until satisfied, then subject to 10% coinsurance after $100 copayment
• **Other emergency room services**	Subject to deductible and coinsurance	Subject to in-network deductible and coinsurance
Hospital inpatient services** Including semi-private or special care room, operating room, ancillary services and supplies. Precertification required.	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hospital outpatient and surgical center services Not including emergency room	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Maternity services		
• **Hospital services**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Physician services**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Breast pump**	Covered at 100%	Subject to deductible and coinsurance
• **Breast feeding support / supplies, counseling**	Covered at 100%	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Mental health and substance abuse services		
• **Inpatient care**** Precertification required	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Outpatient care**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Transitional care**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Office visit Includes chiropractic office visit	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Outpatient laboratory Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Outpatient radiology Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Outpatient therapy services		
• **Occupational therapy**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Physical therapy**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Speech therapy**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Physician services		
• **Hospital services**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Other services in an office**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Preventive benefit		
• **Comprehensive physical examination** ~ 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 and coinsurance	Subject to deductible and coinsurance
• **Digital prostate examination**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Preventive benefit (cont.)		
• **Comprehensive preventive vision examination**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Mammogram to screen for breast cancer** Includes 3D mammogram	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Pap smear to screen for cervical cancer**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Colonoscopy screening for colorectal cancer**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Other screenings for colorectal cancer** ~ Sigmoidoscopy	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Screening laboratory services** Including, but are not limited to: basic metabolic panel, BRCA (1 & 2) 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	Subject to deductible and coinsurance
• **Bone mineral density (dexa scan) to screen for osteoporosis**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Chlamydia screening**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **HPV Screening / counseling**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Ultrasound to screen for an abdominal aortic aneurysm**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Immunizations and vaccinations** Including those needed for travel	Covered at 100%	Subject to deductible and coinsurance
• **Flu vaccine** Including FluMist	Covered at 100%	Subject to deductible and coinsurance
• **Preventive dental care for children up to age 19** Oral exam, prophylaxis, and fluoride treatment; limited to once every 180 days	Covered at 100%	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Skilled nursing facility Limited to 100 days per disability	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Surgical services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Temporomandibular joint disorders or TMJ nonsurgical treatment	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Transplant services		
• **Organ Procurement and acquisition**	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
• **Transplant procedure**	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
• **Transportation and lodging**	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
• **Private duty nursing** Limited to $10,000 per transplant	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
• **Ambulance service** Limited to $2,000 per transplant	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
Vision examinations	Subject to deductible and coinsurance	Subject to deductible and coinsurance
All other covered	Subject to deductible and coinsurance	Subject to deductible and coinsurance

** Case Management Requirement
Participation in case management is mandatory. When a bill for hospitalization or ER occurs subsequent to a contact/offer from a SAS Case Manager that is declined, the first $300 will not be considered for benefit payments. The balance would be considered subject to plan provisions.

Note:
Services received at VA facilities will be payable at the in-network level of benefits. UCR does not apply.

Prior Authorization

The following services require you to obtain prior authorization before receiving the service. For medical pharmacy please check Security Health Plan's website for the full prior authorization list and for further information on prior authorization requests. 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 1-800-570-8760.

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
- Elective outpatient procedures such as, but not limited to: carpal tunnel surgery, knee arthroscopy, back surgeries at all levels.
- Electroconvulsive therapy (after 10 visits)
- Enteral feeding
- Femoro-acetabular surgery for hip impingement syndrome
- Home health including but not limited to skilled nursing, physical therapy, occupational therapy, speech therapy
- Infuse bone graft
- 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
- Spinal cord stimulation
- Swing bed admission
- Technologies not commonly accepted as standard of care
- 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 1-800-570-8760 to find out what medical services require prior authorization.

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 1-800-570-8760 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.

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 1-800-570-8760 to find out what durable medical equipment is on the eligible list.

Prior Authorization Cont.

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, 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.evicore.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

Home Infusion

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.

Pharmacy

- 100% coverage for Preventive Drugs (not subject to deductible). Please refer to the Preventive Medication List at www.securityhealth.org for a list of covered products.
- Limited to a 100 day supply.
- 100% coverage for insulin and diabetic testing supplies included on the Preventive Medication List.
- Insulin and diabetic testing supplies not listed on the Preventive Medication List will require medical exception review from the Security Health Plan Pharmacy Services Department and will be subject to deductible and max out of pocket amounts if applicable. (For insulin pumps and related supplies, please see 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.
- 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.

Subject to the $1,500 individual deductible and $3,000 family deductible per year.

After deductible, 10% coinsurance on next $10,000 per individual and $20,000 per family.

Deductible, copayments and coinsurance apply to the max out of pocket amounts.

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.

Statement of Nondiscrimination

Security Administrative Service, LLC, 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

ATTENTION: 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).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. 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).