




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.securityhealth.org or call 1-800-570-8760. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-570-8760 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>\$1500 individual / \$3000 family for In network \$2500 individual / \$5000 family for Out-of-network</p>	<p>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Preventive care services are covered before you meet your deductible.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount, but a copay or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>\$6400 individual / \$12900 family for In network \$8900 individual / \$17900 family for Out-of-network</p>	<p>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met. The individual in-network out of pocket is limited to \$6,400 when enrolled in a family plan.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance-billing charges, amounts over usual, reasonable & customary (UCR), and health care this plan does not cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.securityhealth.org or call 1-800-570-8760 for a list of network providers.</p>	<p>This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</p>

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist ?	No. You don't need a referral to see a specialist .	You can see the specialist you choose without permission from this plan .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	None
	Specialist visit	10% coinsurance	30% coinsurance	None
	Preventive care/screening/immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Prior authorization is required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.securityhealth.org/prescription-tools or call Pharmacy Services at 1-877-873-5611.	Tier 1 – Preferred generic	10% coinsurance	If you use an Out-of-network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment/coinsurance amount.	Deductible and Out-of-pocket limit applies Limited to a 100 day supply If the participant requests the brand name prescription drug where a generic is available, the participant must pay the applicable generic 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 .
	Tier 2 - Preferred brand drugs and select non-preferred generic	10% coinsurance		
	Tier 3 - Non-preferred brand drugs and select non-preferred generic	10% coinsurance		
	Tier 4 - Specialty drugs	10% coinsurance		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.securityhealth.org

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$100/visit then 10% coinsurance	\$100/visit then 10% coinsurance	Network deductible applies on out of network providers . When a bill for hospitalization or ER occurs subsequent to declining case management, the first \$300 will not be considered for benefit payments. The balance would be considered subject to plan provisions.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Network deductible applies out of network providers .
	Urgent care	10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Precertification is required. When a bill for hospitalization or ER occurs subsequent to declining case management, the first \$300 will not be considered for benefit payments. The balance would be considered subject to plan provisions.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Precertification is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	None
	Inpatient services	10% coinsurance	30% coinsurance	Precertification is required.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	None
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	Precertification is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.securityhealth.org

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Limited to 100 visits per 12 month period. Prior authorization is required.
	Rehabilitation services	10% coinsurance	30% coinsurance	Includes speech therapy, physical therapy, and occupational therapy. Deductible does not apply to office based for in network . Prior authorization is required.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	10% coinsurance	30% coinsurance	Limited to 100 visits per disability. Precertification is required.
	Durable medical equipment	10% coinsurance	30% coinsurance	Prior authorization is required.
	Hospice services	10% coinsurance	30% coinsurance	Home Hospice : Limited to 80 visits per 6 month period Inpatient Hospice : Limited to 30 days per calendar year.
If your child needs dental or eye care	Children's eye exam	No charge	30% coinsurance	Limited to one eye exam at 100% per calendar year for in network .
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge	30% coinsurance	One preventive exam / prophylaxis / fluoride treatment up to age 19 every 180 days.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.securityhealth.org

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Abortion (except in cases when mother's life is in danger)
- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids (Adult)
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the US
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric Surgery
- Chiropractic Care
- Private-duty nursing
- Routine Eye Care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the plan at 1-800-570-8760. 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.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

- [Specialist](#) office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$2,500

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

- [Primary care physician](#) office visits (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Prescription drugs](#)
- [Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$410
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,910

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist coinsurance](#) 10%
- Hospital (facility) [copayment](#) \$100
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$100
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,700

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Addendum

Notice of Nondiscrimination:

Discrimination is against the law

Security Health Plan of Wisconsin, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Security Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Security Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Customer Service. If you believe that Security Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Security Health Plan

Attn: Grievances

1515 North Saint Joseph Avenue

Marshfield, WI 54449-8000

Phone: 715-221-9596 (TTY: 711) Fax: 715-221-9424

Email: shp.appeals.grievance@securityhealth.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Security Health Plan can help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue SW

Room 509F, HHH Building

Washington, DC 20201

Phone: 1-800-368-1019 or 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Access Services:

English:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-472-2363 (TTY: 711).

Spanish:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-472-2363 (TTY: 711).

Hmong:

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).

Chinese:

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-472-2363 (TTY: 711)。

German:

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-472-2363 (TTY: 711).

Russian:

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-472-2363 (телетайп: 711).

Vietnamese:

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-472-2363 (TTY: 711).

Pennsylvania Dutch:

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-472-2363 (TTY: 711).

French:

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-472-2363 (ATS : 711).

Polish:

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-472-2363 (TTY: 711).

Hindi:

ध्यान दः यद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-800-472-2363 (TTY: 711) पर कॉल करा।

Albanian:

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-472-2363 (TTY: 711).

Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-472-2363 (TTY: 711).

Italian:

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-472-2363 (TTY: 711).

Portugues:

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-472-2363 (TTY: 711).

French Creole:

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-472-2363 (TTY: 711).

Oroomiffa (Oromo/Somalia):

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-472-2363 (TTY: 711).