


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


 **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/certificates or by calling 1-800-472-2363.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	\$1,300 per individual \$2,600 per family in network \$2,600 per individual \$5,200 per family out of network 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 <u>deductibles</u> 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 <u>out-of-pocket limit</u> on my expenses?	Yes. \$2,300 per individual \$4,600 per family in network \$4,600 per individual \$9,200 per family out of network	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 <u>out-of-pocket limit</u>?	Premiums, balanced-billed charges, 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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of <u>providers</u>?	Yes. See www.securityhealth.org/directory 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 <u>specialist</u>?	Yes. Except visits to certain specialists require a referral. To find which specialists require a referral, call Security Health Plan Customer Service at 1-800-472-2363, email us at shpcsweb@securityhealth.org , or visit us at www.securityhealth.org/authorization .	Some services require a referral/preauthorization before you receive them. Failure to receive a referral/preauthorization for the services could result in coverage for the service being denied.
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.

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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 in-network **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	20% coinsurance	40% coinsurance	Coinsurance applies after deductible is met
	Specialist visit	20% coinsurance	40% coinsurance	Coinsurance applies after deductible is met
	Other practitioner office visit	20% coinsurance	40% coinsurance	Acupuncture Coinsurance applies after deductible is met
	Preventive care/screening/immunization	Refer to the Preventive Service Guidelines at www.securityhealth.org/preventive for service frequency limits.	Refer to your Schedule of Benefits for specific frequency and coverage limits	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)	20% coinsurance	40% coinsurance	Coinsurance applies after deductible is met
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Coinsurance applies after deductible is met

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

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	Subject to deductible	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	Subject to deductible	Not covered	
	Tier 3	Subject to deductible	Not covered	
	Specialty drugs	Subject to deductible	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	This service does not include emergency room Coinsurance applies after deductible is met
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Coinsurance applies after deductible is met
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	Deductible and copays may apply for services performed in the ER (such as labs, X-rays)
	Emergency medical transportation	20% coinsurance	20% coinsurance	Coinsurance applies after deductible is met
	Urgent care	20% coinsurance	20% coinsurance	When you're in the service area, benefits are payable for urgent care services only when provided by an affiliated provider.

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

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 a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Coinsurance applies after deductible is met
	Physician/surgeon fee	20% coinsurance	40% coinsurance	Coinsurance applies after deductible is met
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	Coinsurance applies after deductible is met
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Coinsurance applies after deductible is met
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	Coinsurance applies after deductible is met
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Coinsurance applies after deductible is met
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	Coinsurance applies after deductible is met
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Coinsurance applies after deductible is met

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

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
<p>If you need help recovering or have other special health needs</p>	Home health care	20% coinsurance	40% coinsurance	Limited to 40 visits per individual per calendar year Coinsurance applies after deductible is met
	Rehabilitation services	20% coinsurance	40% coinsurance	---none---
	Habilitation services	20% coinsurance	40% coinsurance	Certain limitations apply. Please refer to your policy plan documents for more specific information.
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 30 days per individual per confinement Coinsurance applies after deductible is met
	Durable medical equipment	20% coinsurance	40% coinsurance	Coinsurance applies after deductible is met
	Hospice services	20% coinsurance	40% coinsurance	Coinsurance applies after deductible is met

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

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
<p>If your child needs dental or eye care</p>	Eye exam	20% coinsurance	40% coinsurance	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	This policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

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

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 | • Bariatric surgery | • Cosmetic Surgery |
| • Dental care (Adult) | • 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.)

- | | | |
|---------------------|----------------|----------------------------|
| • Chiropractic care | • Hearing aids | • 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:

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- 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.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

—————*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 \$5,240.00
- Patient pays \$2,300.00

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	\$1,300.00
Copays	\$0.00
Coinsurance	\$1,000.00
Limits or exclusions	\$0.00
Total	\$2,300.00

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

- Amount owed to providers: \$5,400
- Plan pays \$4,002.00
- Patient pays \$1,398.00

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	\$1,300.00
Copays	\$0.00
Coinsurance	\$98.00
Limits or exclusions	\$0.00
Total	\$1,398.00

Note: These coverage examples assume single coverage under the plan design

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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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