


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

 **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, refer to www.securityhealth.org/certificates or 1-800-472-2363. 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.cciio.cms.gov or call 1-800-472-2363 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	In network: \$1,300 Indiv/\$2,600 Family; Out network: \$2,600 Indiv/\$5,200 Family	Generally, you must pay all the costs up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment 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/ .
Are there other deductibles for specific services?	No.	You may pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In network: \$2,300 Indiv/\$4,600 Family; Out network: \$4,600 Indiv/\$9,200 Family	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.
What is not included in the out-of-pocket limit ?	Premiums, balanced-billing 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 .
Will you pay less if you use a network provider?	Yes. See www.securityhealth.org/directory or call 1-800-472-2363 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan 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.
Do you need a referral to see a specialist ?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. 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.



- 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	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	Please refer to your policy plan documents for more specific information.
	<u>Preventive care/screening/immunization</u>	Covered at 100%	40% 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	<u>Diagnostic test</u> (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.securityhealth.org/prescription-tools	Generic drugs (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.
	Preferred brand drugs (Tier 2)	Subject to deductible	Not covered	
	Non-preferred brand drugs (Tier 3)	Subject to deductible	Not covered	
	Specialty drugs (Tier 4)	Subject to deductible	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

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	<u>Emergency room care</u>	20% coinsurance	20% coinsurance	Cost sharing may apply for services performed in the ER (such as labs, X-rays).
	<u>Emergency medical transportation</u>	20% coinsurance	20% coinsurance	None
	<u>Urgent care</u>	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. Cost sharing may apply for services performed in the UC (such as labs, X-rays).
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fee	20% coinsurance	40% coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	20% coinsurance	40% coinsurance	Please refer to your policy plan documents for more specific information.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Depending on type of services cost-sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Please refer to your policy plan documents for more specific information.
	Rehabilitation services	20% coinsurance	40% coinsurance	
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	
	Durable medical equipment	20% coinsurance	40% coinsurance	
	Hospice services	20% coinsurance	40% coinsurance	None

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 your child needs dental or eye care	Children's eye exam	20% coinsurance	40% coinsurance	Please refer to your policy plan documents for more specific information.
	Children's glasses	Not covered	Not covered	Glasses are generally not covered; please refer to your plan documents for specifics.
	Children's 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 or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

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 .)		
• Cosmetic Surgery	• Long Term Care	• Routine eye care (Adult)
• Dental Care	• Non-emergency care when traveling outside the U.S.	• Routine foot care
• Infertility Treatment	• Private-duty Nursing	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (if prescribed for rehabilitation purposes)	• Chiropractic Care	• Weight Loss Programs
• Bariatric Surgery	• Hearing aids	

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 your state insurance department, of the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services 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 Appeal 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 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 Security Health Plan at 1-715-221-9258 or 1-844-293-9624. You may also contact the Office of the Commission of Insurance (OCI) at (608) 266-3585 or (800) 236-8517.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standard? 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.

Notice 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:

[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).]

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-472-2363 (TTY:711).]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-472-2363 (TTY:711).]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-472-2363 (TTY:711).]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-472-2363 (TTY:711).]

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next page.* —————

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	\$1,300
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	\$12,800
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,300
Copayments	\$0
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$2,300

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1,300
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	\$7,400
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,300
Copayments	\$0
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,400

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,300
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	\$1,900
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,300
Copayments	\$0
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,400

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