

Schedule of Benefits - Point of Service Central
Group 780394 - SCHOOL DISTRICT OF MOSINEE
Benefit Year: January 1st through December 31st
Effective Date: 07/01/2017



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.	\$1,300 per individual \$2,600 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.	\$2,600 per individual \$5,200 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	20% of the next \$5,000 per individual \$10,000 per family	40% of the next \$5,000 per individual \$10,000 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.	\$2,300 per individual \$4,600 per family Only the family limit above applies to a family plan.	\$4,600 per individual \$9,200 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 and coinsurance	Subject to deductible and coinsurance
Anesthesia services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Chiropractic services	Subject to deductible and coinsurance	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 and coinsurance	Subject to deductible and coinsurance
Hearing examinations	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Home health care	Subject to deductible and coinsurance (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 and coinsurance	Subject to deductible and coinsurance
Hospital emergency room services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hospital inpatient services (Including semi-private or special care room, operating room, ancillary services and supplies)	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
Mental health and substance abuse services		
• Inpatient care	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 visits	Subject to deductible and coinsurance (Preventive exams covered at 100%)	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