Security Health Plan.

1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000
1-800-472-2363 or 715-221-9555

FOR OFFICE USE ONLY

Pre-ex: ☐ Yes ☐ No
Entrant: ☐ New ☐ Late
Pre-ex months ____________
Eff. date ____________

Group Health Insurance Application

Employer name	Group number	☐ Hire date ________ ☐ Recall date ________	Work status: ☐ Actively working ☐ Retired (date) ______ ☐ COBRA Start date ______ End date ______
Coverage desired: ☐ Single ☐ EE + 1 ☐ EE + child(ren) ☐ Family	Plan type: ☐ HDHP ☐ HMO ☐ POS ☐ Indemnity		

Applicant information

Last name	First name	MI	Former last name	Social Security no.	Sex: ☐ M ☐ F	Date of birth __/__/__	Member ID (office use only)

Residence – street address	City	State	ZIP	County
Mailing – street address	**City**	**State**	**ZIP**	**County**

Home phone no. ( )	Work phone no. ( )	Cell phone no. ( )	Email address

For family plan, list all other persons to be included

Last Name	First Name	MI	Former Last Name	Relationship	Social Security No.	Sex M	Sex F	Date of Birth Mo	Day	Yr	Member ID (office use only)
				Spouse							
				☐ Child ☐ Other______ ☐ Stepchild ☐ Grandchild							
				☐ Child ☐ Other______ ☐ Stepchild ☐ Grandchild							
				☐ Child ☐ Other______ ☐ Stepchild ☐ Grandchild							
				☐ Child ☐ Other______ ☐ Stepchild ☐ Grandchild							
				☐ Child ☐ Other______ ☐ Stepchild ☐ Grandchild							

Please complete the following optional information so we can better serve you. Your answers will not affect your enrollment.

		Subscriber	Spouse	Dependent Name ______	Dependent Name ______	Dependent Name ______
Language	What is your preferred spoken language?	☐ English ☐ Specify______	☐ English ☐ Specify______	☐ English ☐ Specify______	☐ English ☐ Specify______	☐ English ☐ Specify______
Language	What is your preferred written language?	☐ English ☐ Specify______	☐ English ☐ Specify______	☐ English ☐ Specify______	☐ English ☐ Specify______	☐ English ☐ Specify______
Race/Ethnicity	What race are you?	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Specify______ ☐ Two or more races	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Specify______ ☐ Two or more races	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Specify______ ☐ Two or more races	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Specify______ ☐ Two or more races	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Specify______ ☐ Two or more races
Race/Ethnicity	What is your ethnic background?	☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Hispanic/Latino ☐ Not Hispanic/Latino

Check the reason and indicate the date for requesting change in coverage (if applicable)

☐ Marriage: Date of marriage _____ ☐ Death: Name of deceased _____ Date of death _____

☐ Divorce: Date of divorce _____ ☐ Other _____

☐ Add dependent: Date added _____ Reason added _____ Marital status (if over age 18) _____

Complete the following questions regarding other insurance information

Will this application for insurance (if accepted) replace coverage for anyone currently insured on an INDIVIDUAL Policy (not through an employer) through Security Health Plan: ☐ Yes ☐ No
If yes, please complete a Health Plan Change Form to cancel the INDIVIDUAL policy.

Is anyone named in this application currently enrolled in Medicare: ☐ Yes, name _____ (complete below) ☐ No

Medicare claim no. _____ Eff. date Part A (hosp.) _____ Eff. date Part B (med.) _____

Were you or any dependents covered under a health plan within the past 63 days: ☐ Yes ☐ No
If yes, attach documentation of the health plan name and dates of coverage (i.e. Certificate of Creditable Coverage is preferred)

Is anyone named in this application covered by any other GROUP health insurance program: ☐ Yes (complete below) ☐ No

If family policy, list names of family members covered _____

Policyholder's name	Cert./Subscriber number	Policy group number	Policyholder's employer

Other insurance company name	Address	Phone number

Coverage: ☐ Single ☐ EE + 1 ☐ EE + child(ren) ☐ Family	Eff. date	Cancellation date

I agree that the above answers are true and complete to the best of my knowledge and are made to induce the issuance of and as part of the policy I am applying for. I apply for enrollment subject to the Terms and Conditions below.

_____ _____
Applicant's signature Date

Terms and conditions

1. All statements and answers in this application are representations made by the applicant on his/her own behalf and for the other persons named in this application to induce the issuance of the contract(s) applied for.
2. The applicant on behalf of himself/herself and for the other persons named in this application agree to provide information as needed to process this application, i.e. previous health insurance coverage. Time served through previous qualifying coverage under an employer-based plan or individual health insurance policy will be credited toward your waiting period if there is less than a 63-day lapse. To determine previous creditable coverage, you should provide us with a "certificate of coverage" from your prior plan(s). A pre-existing waiting period will be applied automatically until we receive your certificate of coverage.
3. Subject to acceptance of this application by Security Health Plan of Wisconsin, Inc., it is understood and agreed that each participant consents to furnish Security Health Plan of Wisconsin, Inc., with all such medical and surgical reports, records, and other information as requested to process claims. This might include signing a form for the release of information from hospitals, doctors, and other health care providers to Security Health Plan of Wisconsin, Inc.
4. Subject to the acceptance of this application by Security Health Plan of Wisconsin, Inc., the applicant authorizes the named group as his/her remitting agent to deduct from his/her wages or salary an amount equal to a) the existing subscription fees or b) the difference between the existing subscription fees and that contribution made by his/her employer.
5. Subject to acceptance of this application by Security Health Plan of Wisconsin, Inc., the applicant agrees to use the services of Security Health Plan participating clinics, hospitals and physicians, except for "out-of-area emergency care" or when referred to a non-participating physician, clinic or facility. Written referrals must be arranged through a participating physician and approved by the Health Plan Medical Director prior to the receipt of services. These requirements do not apply to members enrolled in an Indemnity coverage option.
6. This form is an application for coverage only. Regardless of any advance payment of premiums, the policy applied for will become effective only upon the acceptance of this application by Security Health Plan of Wisconsin, Inc., to be evidenced by the issuance of an identification card and booklet/certificate.

SecurityHealth Plan℠ Reliance $500 - 10% (38166WI0160001) Coverage Period: 01/01/2017 - 12/31/2017

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

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 deductible?	$500 Indiv/$1,000 Family Does not apply to preventive care and benefits with copayments, if applicable.	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**.
Are there other deductibles 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 out–of–pocket limit on my expenses?	Yes. $1,000 Indiv/$2,000 Family	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 out–of–pocket limit?	Premiums 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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	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 specialist?	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.

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

- **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	10% coinsurance	Not covered	None
	Specialist visit	10% coinsurance	Not covered	None
	Other practitioner office visit	10% coinsurance	Not covered	Acupuncture
	Preventive care/screening/immunization	Covered at 100%	Not covered	Refer to the Preventive Services Guidelines at www.securityhealth.org/preventive and your policy plan documents for service frequency limits.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.securityhealth.org	Tier 1	$5 copayment	Not covered	A designated pharmacy may be required for select Specialty drugs. Certain prescribed drugs may have prior authorization requirements or required to use a lower-cost drug(s) prior to coverage being available. Refer to your Formulary for specific tier information.
	Tier 2	$10 copayment	Not covered	
	Tier 3	$20 copayment	Not covered	
	Specialty drugs	Specialty drugs can be found in all 3 tiers.	Not covered	

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.

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

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	This service does not include emergency room
	Physician/surgeon fees	10% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room services	10% coinsurance	10% coinsurance	Deductible and copays may apply for services performed in the ER (such as labs, X-rays)
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	10% coinsurance	10% coinsurance	When you're in the service area, benefits are payable for urgent care services only when provided by an affiliated provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	None
	Physician/surgeon fee	10% coinsurance	Not covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	Not covered	None
	Mental/Behavioral health inpatient services	10% coinsurance	Not covered	None
	Substance use disorder outpatient services	10% coinsurance	Not covered	None
	Substance use disorder inpatient services	10% coinsurance	Not covered	None
If you are pregnant	Prenatal and postnatal care	10% coinsurance	Not covered	None
	Delivery and all inpatient services	10% coinsurance	Not covered	None

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.

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

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 help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	Limited to 60 visits per individual per calendar year
	Rehabilitation services	10% coinsurance	Not covered	Certain limitations may apply. Please refer to your policy plan documents for more specific information.
	Habilitation services	10% coinsurance	Not covered	Certain limitations may apply. Please refer to your policy plan documents for more specific information.
	Skilled nursing care	10% coinsurance	Not covered	Limited to 30 days per individual per confinement
	Durable medical equipment	10% coinsurance	Not covered	None
	Hospice services	10% coinsurance	Not covered	None
If your child needs dental or eye care	Eye exam	10% coinsurance	Not covered	None
	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.

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.

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

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
• Non-emergency care when traveling outside the U.S.	• Private-duty nursing	• Routine foot care (except for certain conditions)
• Weight loss programs		

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:

- 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.**

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.

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

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.**

This Notice of Nondiscrinination:

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.

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, kwiijigo 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.

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

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** $6,540.00
- **Patient pays** $1,000.00

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	$500.00
Copays	$20.00
Coinsurance	$480.00
Limits or exclusions	$0.00
Total	**$1,000.00**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,400.00
- **Patient pays** $1,000.00

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	$500.00
Copays	$480.00
Coinsurance	$20.00
Limits or exclusions	$0.00
Total	**$1,000.00**

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

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.

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.

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.

SecurityHealth Plan℠ Indep $500 - 10% (38166WI0150001)

Coverage Period: 01/01/2017 - 12/31/2017

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

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 deductible?	In network: $500 Indiv/$1,000 Family; Out network: $750 Indiv/$1,500 Family Does not apply to preventive care and in network benefits with copayments, if applicable.	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**.
Are there other deductibles 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 out–of–pocket limit on my expenses?	Yes. In network: $1,000 Indiv/$2,000 Family; Out network: $2,500 Indiv/$5,000 Family	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 out–of–pocket limit?	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	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 specialist?	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.

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

- **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	10% coinsurance	20% coinsurance	None
	Specialist visit	10% coinsurance	20% coinsurance	None
	Other practitioner office visit	10% coinsurance	20% coinsurance	Acupuncture
	Preventive care/screening/immunization	Covered at 100%	Refer to your Schedule of Benefits for coverage limits	Refer to the Preventive Services Guidelines at www.securityhealth.org/preventive and your policy plan documents for service frequency limits.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.securityhealth.org	Tier 1	$5 copayment	Not covered	A designated pharmacy may be required for select Specialty drugs. Certain prescribed drugs may have prior authorization requirements or required to use a lower-cost drug(s) prior to coverage being available. Refer to your Formulary for specific tier information.
	Tier 2	$10 copayment	Not covered	
	Tier 3	$20 copayment	Not covered	
	Specialty drugs	Specialty drugs found in all 3 tiers.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	This service does not include emergency room
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None

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.

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

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 immediate medical attention	Emergency room services	10% coinsurance	10% coinsurance	Deductible and copays may apply for services performed in the ER (such as labs, X-rays)
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	10% coinsurance	10% coinsurance	When you're in the service area, benefits are payable for urgent care services only when provided by an affiliated provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	None
	Physician/surgeon fee	10% coinsurance	20% coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	20% coinsurance	None
	Mental/Behavioral health inpatient services	10% coinsurance	20% coinsurance	None
	Substance use disorder outpatient services	10% coinsurance	20% coinsurance	None
	Substance use disorder inpatient services	10% coinsurance	20% coinsurance	None
If you are pregnant	Prenatal and postnatal care	10% coinsurance	20% coinsurance	None
	Delivery and all inpatient services	10% coinsurance	20% coinsurance	None

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

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 help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	Limited to 60 visits per individual per calendar year
	Rehabilitation services	10% coinsurance	20% coinsurance	Certain limitations may apply. Please refer to your policy plan documents for more specific information.
	Habilitation services	10% coinsurance	20% coinsurance	Certain limitations may apply. Please refer to your policy plan documents for more specific information.
	Skilled nursing care	10% coinsurance	20% coinsurance	Limited to 30 days per individual per confinement
	Durable medical equipment	10% coinsurance	20% coinsurance	None
	Hospice services	10% coinsurance	20% coinsurance	None
If your child needs dental or eye care	Eye exam	10% coinsurance	20% coinsurance	None
	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.

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
• Non-emergency care when traveling outside the U.S.	• Private-duty nursing	• Routine foot care (except for certain conditions)
• Weight loss programs		

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:

- 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.**

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.

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.**

This Notice of Nondiscrinination:

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.

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, kwiijigo 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.

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

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** $6,540.00
- **Patient pays** $1,000.00

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	$500.00
Copays	$20.00
Coinsurance	$480.00
Limits or exclusions	$0.00
Total	**$1,000.00**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,400.00
- **Patient pays** $1,000.00

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	$500.00
Copays	$480.00
Coinsurance	$20.00
Limits or exclusions	$0.00
Total	**$1,000.00**

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

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.

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.

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.