Schedule of Benefits - Point of Service Central
Group - Indep $500 - 10% (38166WI0150001)
Benefit Year: January 1st through December 31st
Effective Date: 01/01/2017

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.

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Your Responsibilities	In Network	Out of Network
Deductible	$500 per individual $1,000 per family	$750 per individual $1,500 per family
Coinsurance	10% of the next $5,000 per individual $10,000 per family	20% of the next $8,750 per individual $17,500 per family
Annual out of pocket (Deductible, coinsurance & copayments)	$1,000 per individual $2,000 per family	$2,500 per individual $5,000 per family

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
Cardiac rehabilitation (phase II)	Subject to deductible and coinsurance (Limited to 36 visits per individual per calendar year)	Subject to deductible and coinsurance (Limited to 36 visits per individual per calendar year)
Chiropractic services	Subject to deductible and coinsurance	Subject to deductible and coinsurance

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
Habilitative therapy		
• **Occupational therapy**	Subject to deductible and coinsurance (Limited to 20 visits per individual per calendar year)	Subject to deductible and coinsurance (Limited to 20 visits per individual per calendar year)
• **Physical therapy**	Subject to deductible and coinsurance (Limited to 20 visits per individual per calendar year)	Subject to deductible and coinsurance (Limited to 20 visits per individual per calendar year)
• **Speech therapy**	Subject to deductible and coinsurance (Limited to 20 visits per individual per calendar year)	Subject to deductible and coinsurance (Limited to 20 visits per individual per calendar year)
Hearing examinations	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Home health care	Subject to deductible and coinsurance (Limited to 60 visits per individual per calendar year)	Subject to deductible and coinsurance (Limited to 60 visits per individual per calendar year)
Hospice care	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hospital and emergency room services		
• **Emergency room facility** (Copayment waived if admitted to hospital as inpatient)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Other 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

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Your Benefits	In Network	Out of Network
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
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
Outpatient therapy services		
• **Occupational therapy**	Subject to deductible and coinsurance (Limited to 20 visits per individual per calendar year)	Subject to deductible and coinsurance (Limited to 20 visits per individual per calendar year)
• **Physical therapy**	Subject to deductible and coinsurance (Limited to 20 visits per individual per calendar year)	Subject to deductible and coinsurance (Limited to 20 visits per individual per calendar year)
• **Speech therapy**	Subject to deductible and coinsurance (Limited to 20 visits per individual per calendar year)	Subject to deductible and coinsurance (Limited to 20 visits per individual per calendar year)

Your Benefits	In Network	Out of Network
Physician services		
• **Hospital services**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Office visits**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Office visits with primary care physician**	1 visit per individual per year covered at 100% before deductible and coinsurance are applied.	Subject to deductible and coinsurance
• **Office visits with specialist**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Other services in an office**	Subject to deductible and coinsurance (Preventive immunizations covered at 100%)	Subject to deductible and coinsurance

Your Benefits	In Network	Out of Network
Preventive benefit Please refer to Security Health Plan's Preventive Service Guidelines at www.securityhealth.org/preventive for service frequency recommendations.		
• **Comprehensive physical examination** (complete physical) ~ Well-baby care ~ Well-child care ~ Adolescent well-care ~ Adult well-care	Covered at 100%	Subject to deductible and coinsurance
• **Gynecological examination** (breast exam and pelvic exam)	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Digital prostate examination**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Preventive hearing test**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Comprehensive preventive vision examination adult** (age 19 and over)	1 every two years then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Comprehensive preventive vision examination pediatric** (under age 19)	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Mammogram to screen for breast cancer**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Pap smear to screen for cervical cancer**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Colonoscopy screening for colorectal cancer**	1 every two years then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Other screenings for colorectal cancer** ~ Sigmoidoscopy ~ Double contrast barium enema ~ Fecal occult blood testing	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	In Network	Out of Network
• **Screening laboratory services** Including, but are not limited to: basic metabolic panel, breast cancer genetic testing, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), pediatric lead poisoning screening, prostate specific antigen (PSA), and urinalysis.	Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Bone mineral density (dexa scan) to screen for osteoporosis**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Chlamydia screening**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Ultrasound for screen of an abdominal aortic aneurysm**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Breast feeding support and counseling**	Covered at 100%	Subject to deductible and coinsurance
• **Immunizations and vaccinations** (including those needed for travel)	Covered at 100%	Subject to deductible and coinsurance
Skilled nursing facility	Subject to deductible and coinsurance (Limited to 30 days per individual per confinement)	Subject to deductible and coinsurance (Limited to 30 days per individual per confinement)
Surgical services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Temporomandibular joint disorders or TMJ non-surgical treatment	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Transplant services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Vision examinations	Subject to deductible and coinsurance	Subject to deductible and coinsurance

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Pharmacy	
• Up to 30 days worth of medication constitutes a 1-month supply. For most maintenance medications you may receive up to a 90-day supply and if applicable, 3 copayments and/or coinsurance and/or deductible will be assessed. • Member liability will be assessed on insulin and diabetic supplies. (This does not include insulin pumps and related supplies. Please refer to the durable medical equipment section of the Schedule of Benefits for coverage.) • 100% coverage for smoking cessation products, limited to 180 days per calendar year, as indicated in the Formulary Guide. • The use of a specialty pharmacy may be required for select medications, as indicated in the Formulary Guide.	$5 copayment per tier 1 prescription or refill. $10 copayment per tier 2 prescription or refill. $20 copayment per tier 3 prescription or refill. 33% coinsurance per tier 4 prescription or refill (Specialty medications). Deductible, copayments and coinsurance may apply to the max out of pocket amounts. If the participant requests the brand name product for a medication where a generic is available, the participant must pay the applicable copayment/coinsurance plus the ancillary charge. The ancillary charge is the cost difference between the brand name product and the generic product. The ancillary charge will not count towards the prescription out-of-pocket limit.

Additional Benefits		
Eyewear • Under age 19: One pair of glasses (frames and lenses) per year limited to a selection of glasses approved by Security Health Plan. One pair of contact lenses per year covered in lieu of glasses. • Age 19 and older: Eyewear is not covered	Subject to deductible and coinsurance	Subject to deductible and coinsurance

Dependent Coverage
Dependent children are covered from birth through the end of the month they attain the age of 26. In addition, a child who meets the criteria above and is a full-time student as defined in this policy has an extension past age 26, if the child was called to federal active duty in the National Guard or in reserve component of the U.S. armed forces while the child was under age 27 and attending, on a full-time basis, an institution of higher learning. Such extension ends on the date described in the full-time student definition in the policy and any previous amendments.

Additional Exclusions and Limitations		
Pediatric dental	Excluded 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 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.
Pedatric services	The age in which certain pediatric services are available is mandated by law. Some services are available to dependents up to age 18 and some to age 19. This is because States may supplement the Federal requirement. Please call Security Health Plan's Customer Service to confirm whether a mandated pediatric service is covered until age 18 or age 19.	The age in which certain pediatric services are available is mandated by law. Some services are available to dependents up to age 18 and some to age 19. This is because States may supplement the Federal requirement. Please call Security Health Plan's Customer Service to confirm whether a mandated pediatric service is covered until age 18 or age 19.
Prior authorization The following services require you to obtain prior authorization before receiving the service. Your health care provider can start the prior authorization process by downloading a printable Prior Authorization Form at www.securityhealth.org/priorauthorization or contact us at 1-800-548-1224.	***Medical Services*** • Abdominoplasty • Air ambulance transport • Amino Acid Formula • Autologous Cultured Chondrocytes • Clinical trials • Cosmetic and reconstructive surgery • Elective inpatient Admission including medical (acute and behavioral health) and surgical • Enteral feeding • Experimental or investigational services • Fecal transplant • Gender reassignment • Genetic testing	***Medical Services*** • Abdominoplasty • Air ambulance transport • Amino Acid Formula • Autologous Cultured Chondrocytes • Clinical trials • Cosmetic and reconstructive surgery • Elective inpatient Admission including medical (acute and behavioral health) and surgical • Enteral feeding • Experimental or investigational services • Fecal transplant • Gender reassignment • Genetic testing

Additional Exclusions and Limitations		
	• Hearing aids for members over 18 years of age • Home health including but not limited to skilled nursing, physical therapy, occupational therapy, speech therapy • Hospice • Infuse bone graft • Intrastromal corneal ring segments • Lung volume reduction surgery • Non-affiliate provider request • Non-emergent ambulance transport • Office procedure with site of service request other than in an office setting • Oral appliance for obstructive sleep apnea • Outpatient procedure with site of service request as inpatient setting • Outpatient therapy treatment (occupational therapy, physical therapy, speech therapy) • Second opinion • Spinal cord stimulation • Swing bed admission • Transplants • TMJ • Elective outpatient procedures such as, but not limited to: carpal tunnel surgery, knee arthroscopy, back surgeries at all levels ***Medical Pharmacy*** • Antibiotic - Antiviral Intravenous Infusion • Antidiarrheals • Antiemetics • Antineoplastics • Biological Response Modifiers • Bone resorption Inhibitors • Botulinum toxin • Colony Stimulating factors • Home Infusion - Chemotherapy	• Hearing aids for members over 18 years of age • Home health including but not limited to skilled nursing, physical therapy, occupational therapy, speech therapy • Hospice • Infuse bone graft • Intrastromal corneal ring segments • Lung volume reduction surgery • Non-affiliate provider request • Non-emergent ambulance transport • Office procedure with site of service request other than in an office setting • Oral appliance for obstructive sleep apnea • Outpatient procedure with site of service request as inpatient setting • Outpatient therapy treatment (occupational therapy, physical therapy, speech therapy) • Second opinion • Spinal cord stimulation • Swing bed admission • Transplants • TMJ • Elective outpatient procedures such as, but not limited to: carpal tunnel surgery, knee arthroscopy, back surgeries at all levels ***Medical Pharmacy*** • Antibiotic - Antiviral Intravenous Infusion • Antidiarrheals • Antiemetics • Antineoplastics • Biological Response Modifiers • Bone resorption Inhibitors • Botulinum toxin • Colony Stimulating factors • Home Infusion - Chemotherapy

Additional Exclusions and Limitations		
	• Hormone modifiers • Hyaluronic acid • Immunoglobulins • Immunosuppressives • Intravenous hydration • Intravenous Immunoglobulin - Subcutaneous Immunoglobulin Infusion • IV Infusion Therapy Authorization Request: TPN and hydration • Intravitreal macular degeneration agents • Parathyroid hormones • Parenteral Nutrition Home Infusion • Prostaglandins • Respiratory agents • Synagis • Total Parenteral Nutrition (TPN)	• Hormone modifiers • Hyaluronic acid • Immunoglobulins • Immunosuppressives • Intravenous hydration • Intravenous Immunoglobulin - Subcutaneous Immunoglobulin Infusion • IV Infusion Therapy Authorization Request: TPN and hydration • Intravitreal macular degeneration agents • Parathyroid hormones • Parenteral Nutrition Home Infusion • Prostaglandins • Respiratory agents • Synagis • Total Parenteral Nutrition (TPN)
Durable medical equipment	For most durable medical equipment (DME), you will need to work with your provider to receive prior authorization from Northwood at 1-866-532-1344.	For most durable medical equipment (DME), you will need to work with your provider to receive prior authorization from Northwood at 1-866-532-1344.
Shared decision making Shared decision-making is a required step for some prior authorizations. After the prior authorization form has been submitted, members will be required to complete shared decision making prior to receiving the following surgeries or specialty consults.	• Carpal tunnel specialty consult • Chronic hip pain specialty consult • Chronic knee pain specialty consult • Hysterectomy with fibroid diagnosis surgery • Low back pain specialty consult	• Carpal tunnel specialty consult • Chronic hip pain specialty consult • Chronic knee pain specialty consult • Hysterectomy with fibroid diagnosis surgery • Low back pain specialty consult
Skilled nursing facility services For the skilled nursing facility services listed, you will need to work with your provider to notify NaviHealth at 1-855-512-7002 (Fax 1-855-847-7243).	• Acute rehabilitation admission • Long term acute care admission • Skilled nursing facilities admission	• Acute rehabilitation admission • Long term acute care admission • Skilled nursing facilities admission

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Additional Exclusions and Limitations		
High end imaging / Radiation oncology For all high-end imaging and radiation oncology services, you will need to work with your provider to receive prior authorization from eviCore healthcare.	**For high end imaging** • www.medsolutionsonline.com • Phone 1-888-693-3211 • Fax an eviCore request form (available online) to 1-888-693-3210 **For radiation oncology** • www.carecorenational.com • Phone 1-888-444-6185	**For high end imaging** • www.medsolutionsonline.com • Phone 1-888-693-3211 • Fax an eviCore request form (available online) to 1-888-693-3210 **For radiation oncology** • www.carecorenational.com • Phone 1-888-444-6185

Statement 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
ATENCION: si habla espanol, tiene a su disposicion servicios gratuitos de asistencia linguistica. Llame al 1-800-472-2363 (TTY: 711). 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).