## Schedule of Benefits - Point of Service Central

**Group - SCHOOL DISTRICT OF COLBY**
**Benefit Year: January 1st through December 31st**
**Effective Date: 07/01/2017**

SecurityHealth Plan℠

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** | $3,000 per individual<br>$6,000 per family | $6,000 per individual<br>$12,000 per family |
| **Coinsurance** | Covered services paid at 100% after deductible. | 20% of the next<br>$10,000 per individual<br>$20,000 per family |
| **Emergency room facility copayment**<br>(Waived if admitted to the hospital as an inpatient) | $100 copayment per visit<br><br>Balance of charge after copayment applies to annual deductible. Copayments continue after deductible has been satisfied. | $100 copayment per visit<br><br>Balance of charge after copayment applies to annual deductible. Copayments continue after deductible has been satisfied. |
| **Annual out of pocket**<br>(Deductible, coinsurance & copayments)<br><br>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. | $4,000 per individual<br>$8,000 per family | $8,000 per individual<br>$16,000 per family |
| **Dependent wrap coverage**<br>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 | Subject to deductible and coinsurance |
| **Anesthesia services** | Subject to deductible | Subject to deductible and coinsurance |

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| Your Benefits | In Network | Out of Network |
|---|---|---|
| **Chiropractic services** | Subject to deductible | Subject to deductible and coinsurance |
| **Durable medical equipment and medical supplies** (Including insulin pump and supplies) | Subject to deductible | Subject to deductible and coinsurance |
| **Hearing examinations** | Subject to deductible | Subject to deductible and coinsurance |
| **Home health care** | Subject to deductible<br><br>(Limited to 40 visits per individual per calendar year) | Subject to deductible and coinsurance<br><br>(Limited to 40 visits per individual per calendar year) |
| **Hospice care** | Subject to deductible | Subject to deductible and coinsurance |
| **Hospital emergency room services** | | |
| • **Emergency room facility** (Copayment waived if admitted to hospital as inpatient) | $100 copayment per visit<br><br>Balance of charge after copayment applies to annual deductible. Copayments continue after deductible has been satisfied. | $100 copayment per visit<br><br>Balance of charge after copayment applies to annual deductible. Copayments continue after deductible has been satisfied. |
| • **Other emergency room services** | Subject to deductible | Subject to deductible and coinsurance |
| **Hospital inpatient services** (Including semi-private or special care room, operating room, ancillary services and supplies) | Subject to deductible | Subject to deductible and coinsurance |
| **Hospital outpatient and surgical center services** | Subject to deductible | Subject to deductible and coinsurance |
| **Maternity services** | | |
| • **Hospital services** | Subject to deductible | Subject to deductible and coinsurance |
| • **Physician services** | Subject to deductible | Subject to deductible and coinsurance |

| Your Benefits | In Network | Out of Network |
|---|---|---|
| **Mental health and substance abuse services** | | |
| • **Inpatient care** | Subject to deductible | Subject to deductible and coinsurance |
| • **Outpatient care** | Subject to deductible | Subject to deductible and coinsurance |
| • **Transitional care** | Subject to deductible | Subject to deductible and coinsurance |
| **Outpatient laboratory services** | Subject to deductible | Subject to deductible and coinsurance |
| **Outpatient radiology services** | Subject to deductible | Subject to deductible and coinsurance |
| **Outpatient therapy services** | | |
| • **Occupational therapy** | Subject to deductible | Subject to deductible and coinsurance |
| • **Physical therapy** | Subject to deductible | Subject to deductible and coinsurance |
| • **Speech therapy** | Subject to deductible | Subject to deductible and coinsurance |
| **Physician services** | | |
| • **Hospital services** | Subject to deductible | Subject to deductible and coinsurance |
| • **Office visits with primary care physician** | Subject to deductible<br><br>(Preventive exams covered at 100%) | Subject to deductible and coinsurance |
| • **Office visits with specialist** | Subject to deductible | Subject to deductible and coinsurance |
| • **Other services in an office** | Subject to deductible<br><br>(Preventive immunizations covered at 100%) | Subject to deductible and coinsurance |

| 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.<br>• Pharmacy mail service may supply maintenance medications in a 90-day supply and if applicable, 2 copayments and/or coinsurance and/or deductible will be assessed.<br>• Copayments and/or coinsurance and/or deductible will be assessed on oral anti-diabetic medications.<br>• 100% coverage for tier 1 and tier 2 insulin and diabetic testing supplies. (Not subject to deductible, if applicable.)<br>• Insulin and diabetic testing supplies not listed on tier 1 or tier 2 of the Formulary Guide will require medical exception review from the Security Health Plan Pharmacy Services Department. (This does not include insulin pumps and related supplies. Please refer to the durable medical equipment section of the Schedule of Benefits for coverage.)<br>• 100% coverage for smoking cessation products, limited to 180 days per calendar year, as indicated in the Formulary Guide.<br>• Over-the-counter (OTC) medications are generally excluded; however, coverage may be provided for selected OTC medications with a prescription authorization, as indicated in the Formulary Guide.<br>• The use of a specialty pharmacy may be required for select medications, as indicated in the Formulary Guide. | $10 copayment per tier 1 prescription or refill.<br><br>$30 copayment per tier 2 prescription or refill.<br><br>$60 copayment per tier 3 prescription or refill.<br><br>$250 copayment per tier 4 prescription or refill (Specialty medications).<br><br>Deductible, copayments and coinsurance may apply to the max out of pocket amounts.<br><br>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. |

## 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 the Certificate has an extension past age 26 IF the child was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was under 27 years of age 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 Certificate.

## 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

**Prior Authorization**

- 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
- 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
- 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.

## 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

## 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

## 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).