This Schedule of Benefits is a sample for preventive care services reference only. Your coinsurance and cost sharing may differ.

Schedule of Benefits – EPO
Benefit Year: January 1st through December 31st
Effective Date: 01/01/2024

SecurityHealth Plan℠
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Security Health Plan certifies that you and any covered dependents have coverage as described in your Policy 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 policy.

This Schedule shows your specific cost-sharing, as well as any additional benefits, limitations or exclusions not shown in your Policy. 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 Policy for details about your coverage**. Benefits are calculated according to the benefit year shown above. **NOTE: All services must be received from affiliated providers, except as otherwise described in the Policy.**

Your Responsibilities	
Deductible	$3,500 per individual $7,000 per family
Coinsurance	30%
Office visit copayment	$25 copayment per office visit (Preventive exams covered at 100%)
Office visit specialist copayment	$75 copayment per office visit
Urgent care copayment	$75 copayment per office visit
Annual out-of-pocket (Deductible, coinsurance & copayments)	$6,500 per individual $13,000 per family

Your Benefits	
Ambulance services	Subject to deductible and coinsurance
Anesthesia services	Subject to deductible and coinsurance
Breast cancer (BRCA 1 & 2) gene screening ~*Requires prior authorization*	Covered at 100% (Limited to 1 visit per lifetime)
Cardiac rehabilitation (phase II)	Subject to deductible and coinsurance (Limited to 36 visits per individual per calendar year)
Care my way	Covered at 100%
Chiropractic services	Subject to deductible and coinsurance
Durable medical equipment and medical supplies ~*Requires prior authorization*	
• **Approved to be dispensed from a supplier**	Subject to deductible and coinsurance
• **Approved to be dispensed from a network pharmacy**	Refer to pharmacy benefit for pharmacy cost-share

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Your Benefits	
Emergency services	
• **Emergency room facility**	Subject to deductible and coinsurance
• **Other emergency services**	Subject to deductible and coinsurance
Habilitative therapy	
• **Occupational therapy** *~Requires prior authorization*	$25 copayment per visit (Limited to 20 visits per individual per calendar year)
• **Physical therapy** *~Requires prior authorization*	$25 copayment per visit (Limited to 20 visits per individual per calendar year)
• **Speech therapy** *~Requires prior authorization*	$25 copayment per visit (Limited to 20 visits per individual per calendar year)
Hearing examinations	Subject to deductible and coinsurance
Home health care *~Requires prior authorization*	Subject to deductible and coinsurance (Limited to 60 visits per individual per calendar year)
Hospice care	Subject to deductible and coinsurance
Hospital services	
• **Inpatient hospital services** (Including semi-private or special care room, operating room, ancillary services and supplies) *~Requires prior authorization*	Subject to deductible and coinsurance
• **Inpatient mental health and substance use disorder services** *~Requires prior authorization*	Subject to deductible and coinsurance
• **Outpatient hospital and surgical services** (not including emergency room)	Subject to deductible and coinsurance
• **Physician hospital services**	Subject to deductible and coinsurance
• **Other hospital services**	Subject to deductible and coinsurance
Infusion therapy	
• **Home infusion services** (when medically appropriate and provider available)	Covered at 100%
• **Outpatient services**	Subject to deductible and coinsurance

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Your Benefits	
Maternity services	
• **Hospital services**	Subject to deductible and coinsurance
• **Physician services**	Subject to deductible and coinsurance
Mental health and substance use disorder services	
• **Outpatient care**	$25 copayment per visit
• **Transitional care**	Subject to deductible and coinsurance
Nutritional counseling	Subject to deductible and coinsurance
Outpatient laboratory services	Subject to deductible and coinsurance
Outpatient radiology services	Subject to deductible and coinsurance
Physician services	
• **Office visits**	$25 copayment per office visit (Copayment does not apply to preventive exams)
• **Office visits with primary care physician (PCP)** A member must have a PCP on file with Security Health Plan. To update your PCP, call Customer Service at 1-844-293-9624 or log in to your My Security Health Plan account at www.securityhealth.org/loginnow.	$25 copayment per office visit 1 visit per individual per year covered at 100% before copayment is applied. (Copayment does not apply to preventive exams)
• **Office visits with specialist**	$75 copayment per office visit
• **Other physician services in an office**	Subject to deductible and coinsurance (Preventive immunizations covered at 100%)

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Your Benefits	
Preventive care services Please visit www.securityhealth.org/preventive or call 1-844-293-9624 for information on service frequency recommendations and a list of preventive screening services. Tests for an existing condition or illness are not preventive care and are subject to your plan's deductible, coinsurance and/or copays.	Scan this code with your smartphone
• **Wellness visit** (comprehensive physical examination) ○ Well-baby care ○ Well-child care ○ Well-adolescent care ○ Well-adult care ○ Interpersonal and domestic violence screening ○ Nutritional screening ○ Screening and counseling for sexually transmitted infections	Covered at 100%
• **Abdominal aortic aneurysm (ultrasound) screening** (age 65 thru 75)	Covered at 100% (Limited to 1 visit per lifetime)
• **Breast feeding support and counseling**	Covered at 100%
• **Cervical cancer screenings** (age 21 thru 65)	
○ Human papillomavirus DNA screening (HPV)	1 every five years then subject to deductible and coinsurance
○ Pap smear screening	1 every three years then subject to deductible and coinsurance
• **Chlamydia screening**	1 per calendar year then subject to deductible and coinsurance
• **Colorectal cancer screenings**	
○ Colonoscopy screening (age 45 and older)	1 every five years then subject to deductible and coinsurance
○ Colonoscopy screening for personal or family history of polyps or colorectal cancer	1 every two years then subject to deductible and coinsurance
○ Sigmoidoscopy screening (age 45 and older)	1 every five years then subject to deductible and coinsurance

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Your Benefits	
○ Sigmoidoscopy screening for personal or family history of polyps or colorectal cancer	1 every two years then subject to deductible and coinsurance
○ Other colorectal cancer screenings ~Fecal occult blood testing (age 45 and older)	1 per calendar year then subject to deductible and coinsurance
• **Gynecological examination** (breast exam and pelvic exam)	1 per calendar year then subject to deductible and coinsurance
• **Hearing screening** (under age 22)	1 per calendar year then subject to deductible and coinsurance
• **Immunizations and vaccinations** (including those needed for travel)	Covered at 100%
• **Laboratory screening services** Please visit www.securityhealth.org/preventive or call 1-844-293-9624 for information on service frequency recommendations and screening laboratory services.	
○ Cholesterol screening (age 40 thru 75)	1 per calendar year then subject to deductible and coinsurance
○ Diabetes Type 2 screening (age 35 thru 70 with BMI 30+)	1 per calendar year then subject to deductible and coinsurance
○ Hemoglobin (A1C) (diabetics)	2 per calendar year then subject to deductible and coinsurance
○ Lead screening (age 1 thru 6)	1 per calendar year then subject to deductible and coinsurance
• **Mammogram to screen for breast cancer** (includes 2D and 3D imaging)	1 per calendar year then subject to deductible and coinsurance
• **Osteoporosis screening** Bone mineral density (dexa scan)	1 every two years then subject to deductible and coinsurance
• **Prostate cancer screenings**	
○ Digital examination	Subject to deductible and coinsurance
○ Prostate specific antigen test (PSA) (age 55 thru 69)	1 per calendar year then subject to deductible and coinsurance
• **Vision screenings**	
○ Comprehensive pediatric/adolescent vision examination (under age 19)	1 per calendar year then subject to deductible and coinsurance

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Your Benefits	
○ Visual impairment screening (age 1 thru 5)	1 per calendar year then subject to deductible and coinsurance
Rehabilitative therapy	
• **Occupational therapy** *~Requires prior authorization*	$25 copayment per visit (Limited to 20 visits per individual per calendar year)
• **Physical therapy** *~Requires prior authorization*	$25 copayment per visit (Limited to 20 visits per individual per calendar year)
• **Speech therapy** *~Requires prior authorization*	$25 copayment per visit (Limited to 20 visits per individual per calendar year)
Skilled nursing facility *~Requires prior authorization*	Subject to deductible and coinsurance (Limited to 30 days per individual per confinement)
Surgical services	Subject to deductible and coinsurance
Temporomandibular joint disorders or TMJ non-surgical treatment *~Requires prior authorization*	Subject to deductible and coinsurance (Limited to 4 physical/occupational visits for diagnosis of TMJ per year)
Transplant services *~Requires prior authorization*	Subject to deductible and coinsurance
Urgent care services	
• **Urgent care office visits**	$75 copayment per office visit
• **Other urgent care services**	Subject to deductible and coinsurance

SAMPLE

Pharmacy	
• Quantities of prescription drugs dispensed are limited to a 30 day supply. • 100% coverage for diabetic testing supplies found on the Choice Diabetic list (not subject to deductible). • $25 maximum copay per month on insulin products found on the Choice Diabetic list (not subject to deductible). • 100% coverage for smoking cessation products, limited to 180 days per year. • The use of a specialty pharmacy may be required for select prescription drugs, as indicated in the Formulary Guide. • 100% coverage for select Selective Serotonin Reuptake Inhibitors (SSRIs) (not subject to deductible). • Prescription drugs may require prior authorization. • Please refer to our website at www.securityhealth.org/prescription-tools for the most up-to-date prescription drug lists. • Eligible subscribers will receive a quarterly over-the-counter (OTC) credit. ○ Please refer to www.securityhealth.org/OTC or call 1-877-216-8533 for benefit information and list of products.	$5 copayment per tier 1 prescription or refill. $50 copayment per tier 2 prescription or refill. $100 copayment per tier 3 prescription or refill. 40% coinsurance per tier 4 prescription or refill (Specialty prescription drugs). Deductible, copayments and coinsurance may apply to the max out of pocket amounts. If the member receives the brand name prescription drug where a generic is available, the member must pay the applicable copayment/coinsurance plus the ancillary charge. The ancillary charge is the cost difference between the brand name prescription drug and the generic prescription drug. 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

SAMPLE

Dependent Coverage
Dependent children are covered from birth through the end of the year 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.
Pediatric 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.

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Prior Authorization Note: It is your responsibility to ensure that the prior authorization is obtained and completed by your health care provider.
Your health care provider should start the prior authorization process by visiting www.securityhealth.org/providers or contact our Provider Assistance Line at 1-800-548-1224. You can also call our Customer Service Department at 1-844-293-9624 to find out what medical services require prior authorization. For a complete list of medical and pharmacy services requiring prior authorizations visit www.securityhealth.org/authorization or scan the QR code with your smartphone. Scan this code with your smartphone

Notice of Nondiscrimination
Security Health Plan of Wisconsin, Inc., complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, religion, disability, age, sex, gender identity, sexual orientation, health status, marital status, arrest or conviction record or military participation in the administration of the plan, including enrollment and benefit determinations.

Limited English Proficiency Language Services
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-844-293-9624 (TTY 711). ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-293-9624 (TTY 711). LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-293-9624 (TTY 711). If you require materials in large print, please call 1-844-293-9624 (TTY 711).

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