TRANSITIONAL EMPLOYER

Certificate of Coverage



2027

SecurityHealth Plan®

Promises kept, plain and simple.

Certificate of coverage

Security Health Plan of Wisconsin, Inc., "Security Health Plan", is a service insurance corporation with its principal office in Marshfield, Wisconsin, organized and existing under Chapter 613, Wis. Stats. This Certificate serves as a key plan document for several types of Security Health Plan coverage, including health maintenance organization (HMO), point of service (POS) and indemnity plans.

Benefits might be paid differently for the HMO, POS and the indemnity plan. Those details are in your Schedule of Benefits. The Schedule of Benefits outlines your plan's deductible, coinsurance and copay amounts associated with different medical or pharmacy services. It is important that you read this Certificate, your Schedule of Benefits and any amendments carefully so you understand your coverage.

Security Health Plan does not directly provide health care services. We pay providers for covered medical services as specified in this Certificate. Security Health Plan has fee agreements with in-network providers who do not bill you for charges that exceed our payment for covered charges. Your choice of an in-network provider or out-of-network provider determines how much Security Health Plan pays for covered services and how much you pay for your health care.



IMPORTANT NOTICE: Security Health Plan pays out-of-network providers based on our Usual, Customary and Reasonable (UCR) fee schedule for covered services. UCR charges are determined by comparing what providers charge for similar services in the same geographical area or using other methods explained in this document. If a provider's charge is higher than our UCR fee, Security Health Plan may pay less, and you will need to pay the extra amount. You will also have to pay any deductibles, coinsurance and copayments. Fees that go over the UCR fee schedule do not count toward your out-of-pocket limits.

Balance billing

Under federal law, you are protected against balance billing in certain circumstances. If you receive emergency services (for which benefits are available under your plan) at an out-of-network provider, the out-of-network provider may not bill you, and may not hold you liable for any amount of such emergency services which is more than any deductible and coinsurance requirements for such emergency services under your plan.

If, while receiving services at an in-network hospital or ambulatory surgical center, you receive services (for which benefits are available under your plan) from an out-of-network provider, the out-of-network provider may not, without providing sufficient notice and obtaining your consent to receive a higher bill:

- bill you
- hold you liable for any amount of such services which is more than any deductible and coinsurance requirements for such services under your plan.

Additional information about your rights and protections against balance billing can be viewed on our website at www.securityhealth.org/no-surprises-act.

Certificate of coverage (continued)

Security Health Plan does not guarantee the quality of an in-network provider's or out-of-network provider's services. Security Health Plan is not liable for the provision of services of any in-network provider or out-of-network provider.

Security Health Plan, in performing its obligations under the policy, is acting only as a health insurer. It is not acting as a plan administrator, sponsor or trustee for the purposes of the Employee Retirement Income Security Act of 1974 (ERISA) or any other federal or state law.

This Certificate is not the contract of insurance. It is merely evidence of insurance provided under the Group Insurance Policy issued to the group policyholder. This Certificate describes the benefits and other features of such insurance. Wisconsin law governs all provisions of the policy. All benefits are provided in accordance with the terms of the policy.

SECURITY HEALTH PLAN OF WISCONSIN, INC.
1515 NORTH SAINT JOSEPH AVENUE
P.O. BOX 8000
MARSHFIELD, WI 54449-8000
Customer Service phone: (800) 472-2363 · 715-221-9555 · TTY: 711 · Fax: 715-221-9500
Email: shpcsweb@securityhealth.org
www.securityhealth.org

Live chat with a Customer Service agent online. You must be a current member and be logged in to your *My Security Health Plan* account. Available Monday - Friday, 8 a.m. - 4:30 p.m.

General description of coverage

Security Health Plan certifies that a group policy has been issued to your employer to insure certain employees. Security Health Plan calls the employer the policyholder. Those who receive Certificates are called covered employees, subscribers and members. An employee's insurance-eligible dependents who are covered under the plan are also called members. The group policy is a contract between your employer and Security Health Plan. Security Health Plan will provide the insurance described here under the terms of that contract. Please contact your employer to examine the policy itself.

The coverage available under this plan may be for an HMO, POS or indemnity plan. Each plan works differently. Your Schedule of Benefits provides more detail on what type of health plan coverage you have.

If you are covered by an HMO plan, coverage is available to you through in-network providers. You can find a list of our in-network providers on our website at www.securityhealth.org/directory. A paper copy of the Provider Directory is available by contacting Security Health Plan's Customer Service Department. The provider and the facility must be within our network.

Benefits are not available for services received from out-of-network providers except in very limited circumstances. For example, a service you seek might not be available from any HMO in-network provider. In this situation, an in-network provider might refer you to or suggest that you go to an out-of-network provider. You will need to contact Security Health Plan before receiving care from an out-of-network provider. Security Health Plan will provide a written decision on whether your services from an out-of-network provider will be covered. If Security Health Plan does approve those services, Security Health Plan will pay the out-of-network provider based on our UCR fee schedule. That means Security Health Plan will pay the out-of-network provider what we would have paid an in-network provider. Any amount not paid will be your responsibility.

If you are covered by a POS plan, you have in-network and out-of-network coverage and benefits. The reimbursement or benefit you receive varies depending on the provider. You have the lowest out-of-pocket cost when you receive care from in-network providers. You have higher out-of-pocket costs when you use out-of-network providers. Security Health Plan pays out-of-network providers based on our UCR fee schedule. That means your out-of-pocket costs will likely be higher for services you receive from out-of-network providers.

If you are covered by an indemnity plan, you can choose any in-network provider or out-of-network provider. Security Health Plan pays out-of-network providers based on our UCR fee schedule. That means your out-of-pocket costs will likely be higher for services you receive from out-of-network providers.

How to use this Certificate

You should carefully and completely read this Certificate, your Schedule of Benefits and any amendments. Each provision is subject to all other provisions. Reading just one or two provisions might not give you a clear or full understanding of your coverage.

We include definitions of terms stated throughout this document in Section XI, titled "Definitions."

Security Health Plan will occasionally amend this Certificate. When that happens, Security Health Plan will send a new amendment for this Certificate to your employer for delivery to each covered employee. Your coverage will change as described in the amendment as of its effective date.

This Certificate replaces and supersedes all Certificates and amendments that Security Health Plan might have previously issued to you. You should keep it in a safe place for your reference.

Covered expenses

Security Health Plan has the sole and exclusive right to interpret and apply the policy's terms, conditions, limitations, exclusions and provisions. This includes factual determinations as to whether benefits are payable. Security Health Plan reserves the right to interpret, modify, remove or add benefits at our sole discretion without prior notice or your approval. No person or entity other than Security Health Plan may make any changes to this policy. Please also see the subsection titled "Waiver and change" in Section VIII.

In certain circumstances, for cost savings or efficiency, Security Health Plan may, at our sole discretion, pay benefits for services not covered under the policy. However, this will not require Security Health Plan to do so in any other similar or dissimilar case.

Security Health Plan may arrange for various people or entities to provide administrative services including claims processing and utilization review management. By accepting this Certificate, you agree to cooperate fully with them.

Your plan might include a list of surgical services and facilities that might allow for added value-based benefits. If a list is indicated on your Schedule of Benefits, your out-of-pocket costs will be lowest for the listed surgeries when you receive them through certain facilities. Although you can choose any surgical provider, the plan's reimbursement will be limited to what Security Health Plan would have paid to those designated facilities. Please see your Schedule of Benefits for details. The terms of this program will be listed on our website at. www.securityhealth.org/members and communicated through membership materials.

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SECTION I – WHERE MEMBERS CAN RECEIVE CARE

Security Health Plan is a health maintenance organization (HMO) that serves residents in certain counties of Wisconsin. Security Health Plan pays for care depending on the type of coverage you have. Please see your Schedule of Benefits for the type of coverage you have.

HMO coverage

If you are covered by an HMO plan, you can receive care from in-network providers. The provider and the facility must be within our network. Benefits are not available for services received from out-of-network providers except in very limited circumstances. For example, a service you seek might not be available from any HMO in-network provider. In this situation, an in-network provider might refer you to or suggest that you go to an out-of-network provider. You will need to contact Security Health Plan before receiving care from an out-of-network provider. Security Health Plan will provide a written decision on whether your services from an out-of-network provider will be covered. If Security Health Plan does approve those services, Security Health Plan will pay the out-of-network provider based on our UCR fee schedule. That means Security Health Plan will pay the out-of-network provider what we would have paid an in-network provider. Any amount not paid will be your responsibility.

POS coverage

If you are covered by a POS plan, you have in-network and out-of-network coverage and benefits. The reimbursement or benefit you receive varies depending on the provider. You have the lowest out-of-pocket cost when you receive care from in-network providers. You have higher out-of-pocket costs when you use out-of-network providers. Security Health Plan pays out-of-network providers based on our UCR fee schedule. That means your out-of-pocket costs will likely be higher for services you receive from out-of-network providers.

Indemnity coverage

If you are covered by an indemnity plan, you can choose to receive care from any in-network provider or out-of-network provider without a referral or prior authorization. Security Health Plan pays out-of-network providers based on our UCR fee schedule. That means your out-of-pocket costs will likely be higher for services you receive from out-of-network providers.

Our most current Provider Directory can be found on our website at http://www.securityhealth.org/directory. A paper copy of the Provider Directory is available by contacting Security Health Plan's Customer Service Department.

How to receive services from out-of-network providers

Unless your health plan, as specified in your Schedule of Benefits, provides access to out-of-network providers or services for emergency or urgent care, services provided by out-of-network providers are not covered by Security Health Plan. POS and indemnity coverage have access to out-of-network providers without referral or prior authorization. However, there are services that require prior authorization and it is the member's or provider's responsibility to request prior authorization. Benefits may be payable for services by an out-of-network provider if Security Health Plan determines that the service is not available from any in-network provider or as stated in your Schedule of Benefits. To request a prior authorization for payment, have your provider contact Security Health Plan before the service is provided. With the exception of emergency or urgent care services, Security Health Plan will not pay for a service that has already been provided by an out-of-network provider, unless otherwise stated in a member's Schedule of Benefits. All of the following criteria for prior authorization must be met:

- The services are not available from any in-network provider.
- The services are a covered benefit under the member's coverage.
- The services are medically necessary and appropriate.

When receiving prior authorization for a service from an out-of-network provider, the prior authorization will state:

- The type or extent of evaluation and/or treatment authorized
- The number of authorized visits
- The period during which the prior authorization is valid
- The location for services.

Any additional services recommended by and received from an out-of-network provider are not covered unless prior authorization is given.

Reimbursement for out-of-network benefits is limited to the UCR charges for cost-effective services. These are subject to applicable deductible, coinsurance and copayment amounts. If a charge is higher than our UCR fee schedule, may pay less than the billed amount. You will need to pay any extra charged beyond the UCR fees, plus your deductible, coinsurance and copayment amounts.

When services are received out of the country you must translate any documents into English and convert foreign currency amounts into U.S. dollars at your expense prior to submitting a claim to Security Health Plan.

Security Health Plan requires an itemized statement of services and paid receipt in English, along with the rate of currency exchange at the time services were received. Member can email this information to rf.shpmain@securityhealth.org, fax to 715-221-9980 or mail to Security Health Plan, Attn: Claims, P.O. Box 8000, Marshfield, WI 54449.



Remember: Except for emergency or urgent care, a recommendation or referral by an in-network provider to receive services from an out-of-network provider is not covered unless prior authorized and approved by Security Health Plan or otherwise stated in a member's Schedule of Benefits. Please have your provider contact Security Health Plan at 1-800-472-2363 before you receive non-emergency or non-urgent services from out-of-network providers. To get a list of in-network providers you will need to visit www.securityhealth.org/directory or contact Security Health Plan's Customer Service Department at 1-800-472-2363.

SECTION II – HOW TO JOIN OUR PLAN

Joining our plan

Discuss your employer's rules and guidelines for joining our plan with your employer. Your employer may impose up to a 90-day waiting period after your hire date or date you become eligible before insuring you. Your employer must notify Security Health Plan of your enrollment in a timely manner to secure coverage. This is best to be received prior to your effective date of coverage, but must be received no later than the last day of your first month of coverage. Your effective date will be based on the waiting period established by your employer.

Who is eligible for coverage

No one can be denied coverage because of a medical condition. An eligible employee is a person who:

- Is a citizen of the United States or a resident legal alien, or living in the United States with a valid work Visa
- Appears on the group policyholder's regular payroll records (excluding employees working on a temporary or substitute basis) and has on file with the group policyholder a completed W-4 tax form

An employee is eligible for coverage if he/she:

- Has started to work for the group policyholder.
- Is actively employed on the effective date of his/her coverage.

People eligible for Security Health Plan coverage include:

- Subscribers – A subscriber is the employee who works for the policyholder.
- Dependents – A person who relies on someone else for health care coverage. A dependent is usually the subscriber's spouse and/or child(ren). Eligible children must be younger than 26 or such other age as shown in the covered employee's Schedule of Benefits and not on active duty with the military, including the National Guard or reserves.
- Child – A subscriber's legal ward, natural child, adopted child, stepchild or a child placed for adoption with a subscriber. A natural child of a dependent child is eligible for coverage through a subscriber until the dependent child is 18.
- Member – A covered person or dependent enrolled for coverage in Security Health Plan.

Coverage for military extension adult dependent child

A dependent child over the age limit shown in the subscriber's Schedule of Benefits may remain insured as a dependent if he/she meets all of the following requirements:

- Called to federal active duty in the National Guard or a reserve component of the U.S. armed forces while under 27 years of age.
- Attending an institution of higher learning on a full-time basis when called to active duty.
- Lost coverage because he or she is no longer a full-time student.
- Applies to an institution of higher education as a full-time student within 12 months from the date the child has fulfilled his or her active-duty obligation.

If all of the above criteria are met, this adult dependent child may be entitled to continued coverage when the dependent is a full-time student at an accepted learning institution.

In the event an adult dependent ceases to be a full-time student due to a medically necessary leave of absence, then coverage must be continued in accordance with the existing law for continued coverage of students on medical leave, and age is not a factor that would affect when such continued coverage would end. Documentation to support the medically necessary leave of absence, under this section, shall be provided to Security Health Plan upon request.

Coverage for disabled dependent child

A dependent child over the age limit shown in the subscriber's Schedule of Benefits may remain insured as a dependent if he/she meets certain requirements. The child must:

- Be unable to support himself/herself with a job because of a developmental disability, severe mental illness or physical handicap, and be primarily dependent upon the employee for support and maintenance
- Have such status before reaching the age limit shown in your Schedule of Benefits
- Be a covered eligible dependent

Security Health Plan requires proof of a child's incapacity and dependency within 31 days after the child reaches the limiting age. You must provide this proof when asked, but not more than once a year after the first two years following the child reaching the limiting age.

You must notify Security Health Plan's Customer Service Department prior to dependent reaching age limit shown in your Schedule of Benefits for coverage to continue.

When to enroll and when coverage begins



Be sure to report any significant life changes to your employer. If you do not report changes that affect your eligibility, you might miss your chance to enroll new dependents or make plan changes based on the qualifying event.

People who are eligible for coverage may enroll with Security Health Plan during an employer's annual enrollment period or special enrollment periods for a qualifying event. Your employer must notify Security Health Plan of your enrollment in a timely manner. This is best to be received prior to your effective date of coverage but cannot be received more than 31 days past your requested effective date. Documentation to validate an adoption is always required. Documentation for other qualifying events may also be required. Examples of qualifying events are:

- Changes in marital status.
- Birth, adoption or legal guardianship of a child.
- Moving into or out of the service area.
- Beginning employment.
- An employment change that causes a loss of group health insurance coverage.
- A loss of coverage under Medicaid or a state children's health insurance program.
- Becoming eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

If you or an eligible dependent lose coverage under Medicaid or a state children's health insurance program, you must request enrollment within 60 days after coverage ends.

If you or an eligible dependent become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program for coverage under this plan, you must request enrollment within 60 days after your or your dependents are found eligible for the assistance.

Coverage of a newborn

A newborn is covered as follows:

- If a covered employee has family coverage, coverage is provided for his or her newborn natural child from the moment of that child's birth. Security Health Plan requests that the covered employee notify his or her employer about the child's birth within 31 days.
- If the covered employee has single coverage at the time of the newborn child's birth, then the child is covered from the moment of that child's birth and for the next 60 days. Prior to the end of the 60-day period, the covered employee must notify his or her employer about the child's birth. If the covered employee fails to notify his or her employer, coverage for the child shall terminate at the end of the 60-day period, unless you add the child within one year of the birth of the child and pay all premium payments due.

When coverage ends

- The date the employer's policy ends.
- The date the covered employee enters military service other than for duty of less than 30 days.
- The day immediately after a covered employee's work status ends or such other date as agreed upon between the employer and Security Health Plan.
- The date of death of the covered subscriber, spouse, dependent or other covered member.
- For a covered employee's spouse, the day he or she divorces the covered employee.
- Security Health Plan can end a member's coverage for fraud, misrepresentation or false information if the member allows someone who is not covered to make a claim. If a member commits fraud to obtain coverage, Security Health Plan can require the member to pay back the benefits that have been paid on the member's behalf.

- Security Health Plan can end a member's coverage in the event of repeated member misconduct and/or abusive or threatening behavior toward Security Health Plan staff.

Termination requests should be submitted in a timely manner and must not exceed 31 days from the last date of allowable coverage.

Extension of coverage

A dependent child over the age limit shown in a covered employee's Schedule of Benefits may remain insured as a dependent if he/she meets certain requirements, if the covered employee's family coverage remains in force. The child must:

- Be unable to support himself/herself with a job because of a developmental disability, severe mental illness or physical handicap, and be primarily dependent upon the employee for support and maintenance
- Have such status before reaching the age limit shown in your Schedule of Benefits
- Be a covered eligible dependent

Security Health Plan must receive written proof of the incapacity and dependency within 31 days of the child reaching this age limit or coverage will not be extended. Security Health Plan will require all over-age disabled dependents to recertify their disabled status annually in order to continue their health care coverage as a dependent. The employee must notify Security Health Plan immediately if such incapacity or dependency ends. The employee must respond to the annual recertification request within 30 days of receipt to provide proof of the continuation of such incapacity and dependency.

To request an extension of coverage, contact Security Health Plan's Customer Service Department.

Continuation of coverage privilege

Wisconsin state continuation (for employers with fewer than 20 employees)

In certain cases you might be eligible under Wisconsin law to continue coverage. Those eligible for continuation of coverage are:

- An employee who is no longer eligible for coverage through the policyholder, except if their employment is terminated for misconduct
- An employee's spouse or dependent who is no longer eligible for coverage because of divorce, annulment or the death of the subscriber

In either case, the member continuing coverage must have been covered under the policy for at least three months immediately before the ending date of coverage.

The policyholder must notify the member of the following within five days of receiving notice to end the member's coverage:

- The member's option to continue coverage under this subsection or convert coverage as provided under "Conversion policy privilege"
- The premium amount the member must pay monthly to continue coverage or to buy the individual Security Health Plan medical expense conversion policy that might be available under "Conversion policy privilege"
- The manner, deadline and place premium payments are to be made and required for continuation of coverage

If you are eligible for continuation of coverage under Wisconsin law, you must elect such coverage. You must also pay the required premium within 30 days after receiving the notice described above to the policyholder. The policyholder must then notify Security Health Plan of your election as soon as reasonably possible in the manner required by Security Health Plan.

Your continuation of coverage may continue until the earliest of the following dates:

- The date you become eligible for other similar group health care coverage or the same coverage under the policy.
- For subscriber's former spouse, the date the covered subscriber is no longer eligible for coverage under the policy.
- The date the member moves out of Wisconsin.
- The date the policy ends.
- The end of the last coverage period for which the subscriber paid the required premium.
- The end of the maximum coverage period stated in the documentation you will receive after you elect continuation of coverage.

If any of the first three of these events occurs, the subscriber must notify the policyholder and Security Health Plan, in writing, as soon as reasonably possible.

The member may change to a Security Health Plan individual conversion policy when continuation of coverage ends unless the member did not pay the required premium.

Conversion to indemnity coverage is only available if the member had indemnity coverage under the group policy. See “Conversion policy privilege.”

Federal COBRA continuation (for employers with an employer size of 20 or more)

If you are no longer eligible for coverage under the policy, like if your job ends, you are a dependent child or a divorced or surviving spouse and their children, you may be eligible for continuation coverage in accordance with the Federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), as amended. For more information about eligibility for continuation coverage under COBRA, talk to the policyholder.

You must contact the policyholder within 60 days of a divorce or a child losing dependent status under the policy to be eligible for COBRA continuation. Security Health Plan is not liable for any extension of coverage that results from the policyholder’s or member’s actions or mistakes.

If a covered employee leaves their job for military service, they might be able to elect to continue their coverage for themselves and any dependents for up to 24 months while in the military. For more information about eligibility for continuation coverage under the Uniformed Services Employment and Re-employment Rights Act (USERRA), talk to the policyholder.

The coverage available under these laws is the same coverage as the member had previously.

SECTION III – PRIOR AUTHORIZATION

To be eligible for coverage, there are certain medical services, durable medical equipment and prescription drugs for which you or your provider are required to contact Security Health Plan and receive an approved prior authorization before you receive the service or care. To find a list of medical services, durable medical equipment, medical benefit drugs and prescription drugs for which prior authorization is required, visit our website at www.securityhealth.org/authorization or call our Customer Service Department at (800) 472-2363.

Types of requests

There are three categories of requests that can be made under this plan. The primary difference between these categories is the time frame for determination and appeal. It is very important to follow the requirements that apply to your type of request.

The three categories of authorization requests are:

1. **Pre-service request:** These are services or items that need approval before you receive them. If the plan requires approval before receiving medical care, this is a pre-service authorization unless it is urgent.
2. **Urgent pre-service request:** This is a special kind of pre-service request for urgent care. If a provider thinks that, without urgent care, your life, health or ability to recover could be at serious risk, it is an urgent pre-service request
3. **Urgent concurrent care request:** This happens when the plan approves ongoing treatment for a set time or number of treatments. There are two types:
    - When the plan reviews and ends the previously approved treatment time or number of treatments.
    - When you request an extension beyond the originally approved treatment time or number of treatments.

How to request a prior authorization for medical services and medical benefit drugs

Your provider should start the prior authorization process by visiting www.securityhealth.org/providers or contact our Provider Assistance Line at (800) 548-1224.Provider assistance can help direct those requests that go to an outside vendor for prior authorization review.

- Prime Therapeutics Management – Non-oncology medical benefit drugs
- Northwood – Durable medical equipment (DME)
- eviCore – High end imaging (CT, MRI, PET), cardiac imaging and catheterizations, , pain management, musculoskeletal services (surgery services.Eviti-oncology services, including chemotherapy and radiation

If your provider is unable to, you may also start the process by calling Security Health Plan's Customer Service Department with the following information:

- Facility referred to and location.
- Doctor referred to (first and last name).
- Date of appointment.
- Services that will be done.

If this is a surgical procedure, discuss, with your provider, submitting the procedure codes and clinical documentation to support the requested services.

For any prior authorization that is in process, we suggest you check *My Security Health Plan* online at www.securityhealth.org/members to verify the status.

It is your responsibility to ensure:

- You are seeing an in-network provider, if services are available in network.
- The prior authorization request is:
    - completed in consultation with your provider.
    - submitted to and received by Security Health Plan.
    - approved by Security Health Plan before you obtain the applicable health care services, or out-of-pocket charges may be incurred.

After the request is reviewed, a written response will be sent to you and/or the provider who submitted the request. The benefit determination(s) will be based upon the information available at the time the request was received.

If we approve your request, our prior authorization will only be valid for:

- The covered person for whom the request was made.
- The health care services and frequency specified in the request and approved by Security Health Plan.
- The specific period of time and service location approved by Security Health Plan as specified in the approval letter.

A new prior authorization request will need to be submitted and reviewed by Security Health Plan if you change the plan you are enrolled in after your request has been approved.

How to request a prior authorization for a pharmacy benefit drug

You, your pharmacy, or your provider can start the prior authorization process by calling our Pharmacy Services Line at 1-877-873-5611 or emailing us at shppharmacyum@securityhealth.org. For any prior authorization that is in process, we suggest you check *My Security Health Plan* online at www.securityhealth.org/members to verify the status.

It is your responsibility to ensure the prior authorization request is:

- obtained and completed in consultation with your provider
- submitted to and received by Security Health Plan
- approved by Security Health Plan before you obtain the applicable prescription drugs

After the request is reviewed, a written response of the decision will be sent to you and the provider who submitted the request. If the pharmacy information was included with the request, then the pharmacy will be notified of the decision.

If we approve your request, the prior authorization will only be valid for:

- The covered person for whom the request was made
- The prescription drug, dosage and duration information specified in the request and approved by Security Health Plan

A new prior authorization request will need to be submitted and reviewed by Security Health Plan if you change the plan you are enrolled in after your request has been approved.

Consequences for failing to obtain a prior authorization

Failure to comply with the prior authorization process outlined in this subsection will result in no benefits being paid under the policy.

Please visit our website at www.securityhealth.org/authorization or call Security Health Plan's Customer Service Department to find out what medical services, medical benefit drugs and prescription drugs require prior authorization. Urgent and emergent care does not require prior authorization.

Notification of initial benefit decision by plan

Pre-service, urgent and non-urgent care request – Security Health Plan will give written notice of the decision on a pre-service, urgent and non-urgent care request, whether the decision is approved or denied.

Notification of denial decision – If Security Health Plan makes a negative decision on any type of request, Security Health Plan will send you written notice. This notice will be easy to understand and will include:

- Description of the services requested.
- Reasons for the denial decision.
- References to the specific Certificate provisions on which the decision is based.
- The procedures and time limits for appealing the decision and member's right to an external review.
- Any internal criteria, including scientific or clinical judgement, used in making the decision will be provided for free upon request.

SECTION IV – MEMBER BENEFITS

Security Health Plan will provide coverage for what we determine to be medically necessary services for members while their coverage is in effect. Benefits are payable only for covered services that are received from an in-network provider, except as specifically noted otherwise in this Certificate, or a member's Schedule of Benefits. In-network providers are listed in the Provider Directory at www.securityhealth.org/directory.

Even if an in-network provider has referred a member to another provider, benefits will only be payable for that provider's services if that provider is an in-network provider or payment is authorized under this Certificate, or a member's Schedule of Benefits.



Members should contact Security Health Plan before they receive a service to determine whether Security Health Plan will provide coverage. HMO members generally must use in-network providers unless prior authorized by Security Health Plan, or otherwise specified in a member's Schedule of Benefits. Non-emergency and non-urgent services from an out-of-network provider are not covered unless they are a covered expense as described in this section or unless a member has coverage, as described in the Schedule of Benefits that provides access to out-of-network providers. Otherwise, an in-network provider must provide Security Health Plan with a written referral, and Security Health Plan must approve referral prior authorization before the services are provided by an out-of-network provider.

Security Health Plan does not always deem a service to be medically necessary or guarantee coverage when a provider has prescribed, ordered, recommended or approved a treatment, service or supply, or has informed a member of its availability.

Medical services, supplies and treatment are covered expenses when they are:

- Incurred while a member's coverage is in effect
- Received from an in-network provider, non-emergency services provided at an in-network facility provided by an out-of-network provider
- Received from an out-of-network provider, but only with prior authorization
- Received from an out-of-network provider for emergency or urgent care
- Listed as a covered expense under this Certificate
- Consistent with the member's Schedule of Benefits
- Medically necessary

Visit www.securityhealth.org/authorization for a list of services or items requiring prior authorizations.

Your provider should start the prior authorization process by visiting www.securityhealth.org/providers or contacting our Provider Assistance Line at (800) 548-1224.

In certain circumstances, for purposes of overall cost savings or efficiency, Security Health Plan may, in our discretion, offer benefits for services that would otherwise not be covered health services. The fact that we do so in any particular case shall not in any way be deemed to require Security Health Plan to do so in other similar cases.

Ambulance services and non-ambulance transport

Covered

- Licensed professional air and ground ambulance services for emergency medical care and transportation to the nearest hospital where appropriate medical care is available
- Licensed professional air and ground ambulance services that provide transportation to a hospital that offers care not available at the original hospital
- If a member declines ambulance transport in the event of a glycemic event, seizure or respiratory distress symptoms that become stabilized, ambulance services would still be covered

Not covered

- Ambulance transport to a home or outpatient setting
- Medical van transportation
- First responders and rescue services
- Transportation from an acute facility to a sub-acute setting

- Ambulance services in connection with emergency medical care when the ambulance responds but you decline transportation via ambulance

Limitations
Prior authorization is required for non-emergency transport.

Anesthesia services

Covered
Anesthesia services related to surgical, maternity or other services that are covered by this plan for treatment of illnesses or injury are covered.

Limitations
Coverage only applies to services provided under this plan.

Autism spectrum disorders

Covered
- Medically necessary intensive services performed in an outpatient setting by a qualified health provider, professional, therapist or paraprofessional
- Medically necessary non-intensive services performed in an outpatient setting by a qualified health provider, professional, therapist or paraprofessional

Not covered
The following services are not covered under autism spectrum disorders:
- Auditory integration training (sensory stimulation to improve brain processes)
- Chelation therapy (removing heavy metals from the body)
- Custodial or respite care
- Hyperbaric oxygen therapy
- Special diets or supplements
- Treatments offered in schools that are not related to the goals of the treatment plan
- Therapy, treatment or services when provided to a member who is residing in a residential treatment facility, inpatient treatment or day-treatment facility
- Treatment from parents or legal guardians who are otherwise qualified providers, supervising providers, therapists, professionals or paraprofessionals when the treatment is rendered to their own children

Cardiac rehabilitation

Covered
- Phase I (inpatient) services are covered.
- Phase II services received at a facility with a certified cardiac rehabilitation program are covered when the member has a recent history of a cardiac event or any cardiac event for which cardiac rehabilitation is appropriate.

Not covered
Cardiac rehabilitation services beyond Phase II are not covered.

Limitations
See Schedule of Benefits for limits on number of covered visits.

Chiropractic services

Covered
- Services to treat acute musculoskeletal conditions by manual manipulation therapy are covered. Diagnostic services are limited to medically necessary radiology. Treatment is limited to conditions related to the spine or joints.
- Dry needling performed by a licensed provider is covered.

Not covered
Security Health Plan will not provide coverage for:
- Active release technique

- Active therapeutic movement (ATM2)
- Applied spinal biomechanical engineering
- Atlas orthogonal technique
- Bioenergetic synchronization technique
- Biogeometric integration
- Blair technique
- Chiropractic biophysics technique
- Coccygeal meningeal stress fixation technique
- Computerized radiographic mensuration analysis for assessing spinal misalignment
- Cranial manipulation
- Digital motion x-ray
- Directional non-force technique
- Infrared therapy
- Iontophoresis
- Koren specific technique
- Maintenance chiropractic care
- Manipulation for infant birth trauma
- Manipulation for infant colic
- Manipulation for internal (non-neuromusculoskeletal) disorders (applied kinesiology)
- Manipulation under anesthesia
- Moire contourographic analysis
- Myofascial release
- Network technique
- Neural organizational technique
- Neurocalometer/nervoscope
- Neuro emotional technique
- Para-spinal electromyography (EMG)/surface scanning EMG - Spinoscopy
- Physical performance tests
- Spine-adjusting devices (e.g. ProAdjuster, PulStarFRAS, Activator)
- Thermography
- Upledger technique and cranial sacral therapy
- Webster technique (for breach babies)
- Whitcomb technique

Limitations
See Schedule of Benefits for limits on number of covered dry needling services.

Clinical trials

A qualifying clinical trial means any phase of a clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

- The study or investigation is approved or funded (including funding through in-kind contributions) by one or more of the following:
    - The National Institutes of Health
    - The Centers for Disease Control and Prevention
    - The Agency for Health Care Research and Quality
    - The Centers for Medicare and Medicaid Services
    - Cooperative group or center of any of the above four entities, the Department of Defense or the Department of Veterans Affairs
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    - The Department of Veterans Affairs, the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the Department of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review

- The study or investigation is conducted under an investigational new drug application by the U.S. Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application

Covered
Routine patient care costs incurred during participation in a qualifying clinical trial are covered if:
- Items, services and prescription drugs are provided in connection with a qualified clinical trial
- You provide medical and scientific information establishing that your participation in the qualified clinical trial is appropriate according to the trial protocol with respect to the treatment of cancer or other life-threatening disease or condition

Not covered
Routine patient care does not include the following items and services and is not covered under clinical trials:
- The investigational item, device, medication or service itself
- Items and services provided solely to satisfy data collection and analysis needs, and that are not used in your direct clinical management

Limitations
Services related to clinical trials require prior authorization. Please visit our website at www.securityhealth.org/authorization for a list of services or items requiring prior authorizations.

Contraceptive drugs and devices

Covered
- Contraceptive drugs or devices prescribed by a provider
- Outpatient consultations, examinations, procedures and medical services that are necessary to prescribe, administer, maintain or remove a contraceptive

Limitations
- Prescribed generic contraceptive drugs are covered at 100%. Brand-name contraceptives are covered at 100% when no generic is available. If either a covered brand-name prescription drug, for which a generic equivalent is available, or a generic prescription drug is prescribed, the prescription will be filled with the generic version. If you receive the brand-name prescription drug, then you will be responsible for the copay and coinsurance that applies to the brand-name prescription drug plus an ancillary charge. The ancillary charge is equal to the difference between the cost of the brand-name prescription drug and the generic prescription drug. The ancillary charge will not count towards your out-of-pocket limit.
- Over-the-counter contraceptives, including birth control pills, are not covered unless approved by the U.S. Food and Drug Administration and prescribed by a provider.
- The morning-after pill is not covered unless prescribed by a provider.

Cosmetic services and reconstructive procedures

Covered
- Reconstructive procedures when the primary purpose of the procedure is either of the following:
    - Treatment of a medical condition
    - Improvement or restoration of physiologic function
- Breast reconstruction after a covered mastectomy, including reconstruction of the breast upon which surgery was performed as well as reconstruction of the other breast to produce a reasonably symmetrical appearance, as determined by Security Health Plan; breast reconstruction includes initial and replacement breast implants following a mastectomy
- Treatment of physical complications at all stages of mastectomy
- Services to repair a birth defect causing functional impairment in an enrolled child
- Reconstructive procedures when coverage is required by law or is medically necessary

Not covered
Cosmetic services as determined by Security Health Plan, including but not limited to:
- Any procedure which is primarily to improve physical appearance

- Services and procedures to improve the patient's self-esteem, personal well-being, or to treat emotional problems or disorders
- Services and procedures provided in connection with, or resulting or arising from complications of cosmetic services or procedures
- Scar or tattoo removal or revision procedures
- Skin-abrasion procedures performed as acne treatments
- Liposuction or removal of fat deposits
- Spider vein treatments
- Hair removal or replacement
- Excision or elimination of hanging skin on any part of the body
- Surgical treatment of excessive sweating (hyperhidrosis)
- Removal or replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure.
- Cryotherapy or cool sculpting
- Lymphedema surgical treatment that is considered experimental or investigational

Limitations

- Services related to cosmetic services and reconstructive procedures require prior authorization. Please visit our website at www.securityhealth.org/authorization for a list of services or items requiring prior authorizations.
- Chemical peel or chemical exfoliation is only covered for actinic keratosis.
- Dermabrasion is only covered for actinic keratosis, perioral dermatitis, rhinophyma, basal cell carcinoma, carcinoma in-situ and other pre-malignant skin lesions as determined by Security Health Plan.

Dental care and oral services

Covered

- Dental services for Temporomandibular Disorders (also known as Temporomandibular Joint Disorders, TMJ)
    - Medically necessary surgical and non-surgical services for the treatment of Temporomandibular Joint (TMJ) disorders, including prescribed intraoral splint therapy services
- Dental and oral surgical services
    - Oral surgery services for impacted wisdom teeth.
    - Oral surgery services for a tooth root without the extraction of the entire tooth, excluding root canal therapy.
    - Oral surgery services for the tissues of the mouth when not performed in connection with the extraction or repair of teeth.
    - Orthodontia, dental implants and oral surgery treatment related to cleft lip and palate for a dependent child.
    - Orthognathic surgery (see limitations).
    - Accident-related dental services to treat an injury and to repair (not replace) sound, natural teeth (see limitations). A sound and natural tooth has no restorative treatment and no disease prior to the injury; for example, a tooth with no crowns, root canals, periodontal condition and no fractures, one that is not in need of treatment for any reason other than the accidental injury.
    - Medical facility and general anesthesia services related to dental care and performed in a hospital or ambulatory surgery center setting if any of the following apply:
        - The member has a chronic disability that meets Wisconsin statute conditions.
        - The member has a medical condition that requires hospitalization or general anesthesia for dental care.
        - The member is a child under the age of 5.

Not Covered

- Exposure or extraction of teeth other than removal of impacted wisdom teeth
- Repair or replacement of crowns, bridges, dentures and implants
- Routine diagnostic and preventive dental services, including pediatric dental services
- Dentures and services in preparation for dentures
- Bridges
- Dental implants and related services
- Bleaching of teeth
- Veneers

- Services due to non-accidental damage to teeth such as dental damage that happens as a result of normal activities of daily living or inappropriate use of the teeth
- Elective orthodontic, cosmetic, periodontic or general dental care not related to treatment of temporomandibular joint disorder (TMJ)
- Other dental procedures or treatment whether the dental treatment is needed because of a primary dental problem or as a manifestation of a medical treatment or condition

Limitations

- Tooth extraction may be covered when performed by an oral surgeon and deemed medically necessary as an integral part of treatment for another covered condition.
- Tooth extraction may be covered if deemed medically necessary in preparation for radiation treatment for cancer involving the jaw.
- Services to repair damage caused by accidental injury must begin within three months of the accident, unless extenuating circumstances exist, such as prolonged hospitalization or presence of fixation wires from fracture care, and be completed within 12 months of the accident, unless there are extenuating circumstances.
- TMJ appliance is limited to one every two years.
- Radiologic intervention is limited to one service for the diagnosis of TMJ.
- See your Schedule of Benefits for limits on the number of visits for TMJ.
- Orthognathic surgery is covered for a physical abnormality that prevents normal function of the upper and/or lower jaw and is medically necessary to attain functional capacity of the affected part, including skeletal anomaly, acute traumatic injury, dislocation, cancer, TMJ or severe sleep apnea.

Diabetes services

Durable medical equipment approved to be dispensed from an in-network pharmacy will be subject to the pharmacy benefit cost-share.

Covered

- The installation and use of an insulin infusion pump, and all other equipment and supplies, including insulin and other prescription drugs, used in the treatment of diabetes
- Prescription diabetic supplies dispensed by in-network pharmacies
- Diabetic education programs prescribed by your provider

Limitations

- Services related to diabetes durable medical equipment require prior authorization. Please visit our website at www.securityhealth.org/authorization for a list of services or items requiring prior authorizations.
- Purchase of a traditional (non-patch) pump is limited to one every year and requires prior authorization. You must see an in-network endocrinologist and use the pump for at least 30 days before the pump is purchased.

Durable medical equipment, prosthetics, orthotics and medical supplies

Durable medical equipment is:

- Ordered by a physician for outpatient use primarily in a home setting
- Used for medical purposes
- Not consumable or disposable except as needed for health reasons
- Not of use to a person who doesn't have a disease or disability

Some examples of durable medical equipment include:

- Equipment to assist mobility, such as a standard wheelchair
- A standard hospital-type bed
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks)
- Delivery pumps for tube feedings including tubing and connectors
- Braces to treat curvature of the spine and braces to stabilize an injured body part, including necessary adjustments to shoes to accommodate braces
- Diabetic shoe with diabetic shoe inserts
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure
- Burn garments

- Insulin pumps and all related necessary supplies (as described under Diabetes services)

Security Health Plan will cover the requested piece of equipment that meets the minimum specification to meet member functional needs. Coverage is subject to deductible, coinsurance and copays. The member is responsible for the full cost of the requested piece of equipment that the member rents or buys that exceeds the minimum specifications.

Covered

- Breast pumps
- Nutrition therapy: Amino acid-based formula for infants up to 1 year old with demonstrated formula-protein intolerance, cystic fibrosis, amino acid, organic acid, fatty acid, metabolic or malabsorption disorders
- External prosthetic devices that replace a limb or an external body part limited to artificial legs, arms, feet and hands, artificial eyes, ears and noses, breast prostheses, repair, replacement or revision of prostheses made necessary by normal wear and use
- Brace devices meeting Security Health Plan's coverage criteria

Not covered

- Durable medical equipment and supplies not on the eligible list
- Other disposable supplies and appliances except as listed in this section and Section IV under “Prescription drug coverage”
- Repair, replacement or revision of properly functioning durable medical equipment including, but not limited to, loss, damage or theft
- Duplicate durable medical equipment including repair, replacement or revision of duplicate items
- Durable medical equipment and medical supplies for your comfort, personal hygiene, convenience or athletic-related conditions including, but not limited to, air conditioners, air cleaners, humidifiers, physical fitness equipment, disposable supplies, self-help devices not medical in nature, duplicate pieces of equipment, deluxe/nonstandard equipment and back-up equipment
- Shoe inserts

Limitations

- Durable medical equipment and supplies prescribed by a provider require prior authorization; you or your provider can call Northwood, Inc., at 1-866-532-1344 for coverage concerns or questions on supplies/DME.
- The member is responsible for the cost difference between the requested piece of equipment that Security Health Plan deems appropriate and what the member rents or buys if it exceeds the guideline of minimum specifications to meet the member's functional needs.
- Replacement of devices, except after their life expectancy of five years, unless otherwise specified within this Certificate.
- Breast pump – one per birth.

Emergency services

In-network hospital emergency rooms should be used whenever possible. If a member is unable to reach an in-network provider, the member should go to the nearest appropriate medical facility. Emergency care received from an out-of-network provider will be covered at the same level of benefits as services provided by an in-network provider.

If a member is treated in one emergency room and the member’s medical condition requires the member to be transported to another emergency room, the member’s cost sharing will apply to each site of service.

Out-of-network follow-up services related to an emergency service require prior authorization. Please visit our website at www.securityhealth.org/authorization for a list of services or items requiring prior authorizations.

Covered

- In-network and out-of-network emergency services
- Professional services at the time of the emergency room visit with licensed providers
- Diagnostic services including laboratory and radiology services

Not covered

Take home prescription drugs and supplies dispensed at the hospital at the time of discharge for use at home, including discharge from emergency visit, are not covered.

Limitations
Follow-up care must be received from an in-network provider, unless otherwise authorized by Security Health Plan or if the member's coverage, as defined in the Schedule of Benefits, covers out-of-network providers.

Fertility services

Covered:
Services to diagnose infertility, including professional, hospital and outpatient services received from or under the direction of a provider are covered.

Not covered:

- Prescription drugs prescribed for fertility or administered by a provider
- Treatment of infertility
- Assisted reproductive services including but not limited to:
    - In vitro fertilization (IVF).
    - Gamete intrafallopian transfer (GIFT).
    - And related or similar services, regardless of reason or diagnosis.
- Reversal of sterilization surgery

Foot care services

Covered
Foot care that includes the examination and treatment for individuals with a systemic disease such as metabolic, neurologic or peripheral vascular disease is covered.

Gender affirmation services

Gender affirmation services are covered when provided by or under the direction of a physician when a diagnosis of gender dysphoria has been confirmed.

Covered

- Hormone therapy.
- Gender-affirming surgical procedures.

Not covered

- Cosmetic procedures.
- Drugs for hair loss or growth.
- Drugs for sexual performance.
- Preservation of fertility services including, but not limited to, sperm, embryos and oocytes.
- Reversal of genital surgery.

Genetic services

Covered

- Genetic testing received in an office or outpatient hospital when test results will directly affect treatment decisions or frequency of screening for a disease or when results of the test will affect reproductive choices.
- Molecular genetic testing of pathological specimens such as tumors, blood or body fluids.

Not covered:

- Genetic testing when performed in the absence of symptoms or high-risk factors for a genetic disease.
- Genetic testing when knowledge of genetic status will not affect treatment decisions, frequency of screening for the disease or reproductive choices.
- Genetic testing performed in response to direct-to-consumer marketing and not under the direction of a provider.

Limitations:

Services related to genetic testing require prior authorization. Please visit our website at www.securityhealth.org/authorization for a list of services or items requiring prior authorizations.

Hearing aids, implantable hearing devices and related services

Benefits are available for a hearing aid that is purchased as a result of a prescription from a provider. Benefits are provided for a standard hearing aid and for charges associated with fitting and testing.

Covered

- Hearing aids and implantable hearing devices prescribed by an in-network provider, licensed audiologist or in accordance with accepted professional, medical, audiological standards and dispensed from an in-network hearing aid provider; to find an in-network hearing aid provider, go to www.securityhealth.org/Find-A-Doctor.
- Batteries for cochlear implants.
- Batteries with the initial set up of the hearing aid.

Not covered

- Hearing aid cords.
- Repairs, replacement or programing for a hearing aid or a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

Limitations

- Hearing aids limited to one every three years per ear.
- Implantable hearing devices limited to one per ear, per lifetime.
- Cochlear implant batteries limited to one per each hearing aid every three years or when medically necessary due to loss or damage.
- Cochlear implant processor limited to one per each implant every five years.

Home care services

Home health agency services that are ordered by a provider and provided in the member's home qualify as home care services. Services must be provided by:

- a licensed or Medicare certified home health agency
- or certified rehabilitation agency and provided by a:
    - registered nurse (RN)
    - licensed practical nurse (LPN) who is supervised by an RN
    - home health aide
    - physical therapist (PT)
    - occupational therapist (OT)
    - speech therapist (ST)
    - respiratory therapist (RT)

Security Health Plan will determine whether benefits are available by reviewing the skilled nature of the service and the need for physician-directed medical management.

Benefits are available only when the home health agency services are provided on a part-time, intermittent care schedule and when skilled care is required. Skilled care includes skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- It is ordered by a physician.
- It requires clinical training in order to be delivered safely and effectively.
- Coverage is limited to cases where hospitalization or skilled nursing facility confinement would be necessary if a home care service was not provided.
- Must be confined to the home and be physically unable to get needed medical services on an outpatient basis.
- The maximum weekly benefit payable for home care services will not be more than the benefits payable for the total weekly allowed amounts for skilled nursing care in a licensed skilled nursing facility, as determined by Security Health Plan.

- All home care services, including home health aide services, must be medically necessary.

Covered

- Part-time or intermittent home skilled nursing care by or under supervision of a registered nurse.
- Part-time or intermittent home health aide services when part of the home care services plan and are under the supervision of a registered nurse.
- Physical, respiratory, occupational or speech therapy.
- Medical supplies, prescription drugs and laboratory services if needed under the home care services plan and ordered by a physician and would otherwise be covered in an inpatient hospital setting.
- Nutrition counseling provided or supervised by a registered or certified dietitian when part of the home care services plan.
- Approved Security Health Plan intravenous (IV) therapy ordered by physician and performed in member's home.
- Medical education services provided by licensed care professionals when disease education for patient self-management is important or when member needs a trained professional to teach him or her about the disease.

Not covered

- Home care services provided by the member's immediate family or others residing with the member.
- Services deemed as custodial (e.g. activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair).

Limitations

- See your Schedule of Benefits for limits on the number of visits you can have each year.
- All home-infusion medications are limited to select home-infusion providers and infusion in the home setting.
- Each visit by a person providing services under a home care services plan, evaluating the members need or developing a plan counts as one visit. Each period of up to four consecutive hours of home health aide services in a 24-hour period counts as one home care services visit.
- The maximum weekly benefit payable for home care services will not be more than the benefits payable for the total weekly allowed amounts for skilled nursing care in a licensed skilled nursing facility.

Hospice care

The member's primary physician must certify that the member's life expectancy is six months or less. Services must be provided by a licensed, certified hospice agency.

Covered

Services including respite care are only covered when ordered by a licensed provider and provided by a hospice program to terminally ill persons and their families.

Not covered

Room and board charges are not covered.

Infusion therapy

Covered

- Infusion therapy performed in an office, outpatient or inpatient setting.
- Infusion therapy performed in a home setting when medically appropriate and from an in-network provider.

Limitations

- Some infusion therapy services require prior authorization.
- All home-infusion medications are limited to select home-infusion providers and infusion in the home setting.

Inpatient hospital services

Inpatient hospital services include services and supplies provided during an inpatient stay at a hospital.

Covered

- Inpatient hospital services for a physical illness or injury, including:
    - Room and board, including nursing services, for occupancy of a semi-private room.

    - Private room charges when physician-ordered and medically necessary.
    - Medically related treatments in hospitals, and services and supplies.
    - Intensive care unit room and board.
- Inpatient rehabilitation facility for intensive rehab services, including:
    - Room and board, including nursing services, for occupancy of a semi-private room.
    - Private room charges when physician-ordered and medically necessary.
    - Medically related treatments, services and supplies.

Not covered

- Hospital stays, if care could be safely and effectively provided in a less acute setting.
- Extended hospital stays or personal comfort or convenience items for reasons other than medical necessity.
- Take home prescription drugs and supplies dispensed at the hospital at the time of discharge for use at home, including discharge from emergency or urgent care visits.

Limitations

- Inpatient prior authorization from Security Health Plan is required. The provider is required to contact Security Health Plan at least 14 days before all elective inpatient surgeries.
- Prior authorization is required for scheduled inpatient rehabilitation facility and long term acute care (LTAC) admissions.
- If confined to an out-of-network hospital as an inpatient due to medical emergency, we reserve the right to coordinate your transfer to an in-network hospital once you are stable and can be safely moved.
- Notification is required for urgent or emergency inpatient hospital admissions. In accordance with Section Ins. 9.38 (4), Wis. Adm. Code, notification is required 48 hours after receiving services, or when it is medically feasible for the enrollee to provide the notice, whichever is later.
- Admission to another hospital is not covered when care is available at the in-network hospital where you were first admitted unless prior authorization is received.

Kidney disease services

Covered

Inpatient and outpatient kidney-disease treatments are covered, including:

- Dialysis
- transplantation
- donor-related services.

Note: Members with End Stage Renal Disease (ESRD) should contact Medicare about enrollment and benefit options.

Maternity services

Covered

- Prenatal, delivery and postnatal care performed by a licensed provider including a certified nurse midwife.
- Additional prenatal visits for high-risk pregnancy performed by an obstetrical provider.
- Services for miscarriage(s).
- Abortion procedures that end a mother's pregnancy if they are required because of maternal illness, fetal illness, disease or anomalies, and if they comply with all applicable laws.
- Services for medical complications that arise from a spontaneous or induced abortion.
- Water delivery/birth.

Security Health Plan will follow the federal mandated timeframes for delivery:

- 48 hours following a vaginal delivery.
- 96 hours following a cesarean section.

If the hospital stay exceeds the allowed timeframe, your provider is required to contact Security Health Plan based on the inpatient hospital requirement.

Not covered

- Childbirth and other educational classes, other than breast feeding support and counseling.
- Home delivery and home visits.

- Services performed by a licensed midwife or certified professional midwife.

Mental health and substance-use disorder services

Services related to mental health can be performed in the following settings: inpatient, residential, transitional and outpatient.

The following benefits for mental health and substance abuse services must be medically necessary and received from an in-network behavioral provider.

We cover mental health evaluations and treatment ordered by a Wisconsin court when the services ordered are covered under this document.

Covered

Inpatient hospital services

Inpatient hospital services related to treatment of nervous or mental disorders or substance-use disorders are covered. These include:

- Room and board, including nursing services, for occupancy of a semi-private room.
- Private room charges when physician-ordered and medically necessary.
- Medically related treatments in hospitals to include operating room, ancillary services and supplies.
- Intensive care unit room and board.

Transitional treatment arrangements

Medically necessary services for the treatment of nervous or mental disorders or substance-use disorders are covered, including:

- Residential treatment services
- Day treatment services or partial hospitalization program
- Intensive outpatient programs
- Community support programs (CSPs)
- Crisis intervention

Outpatient services

- Nonresidential services for the treatment of nervous or mental disorders or substance use disorders directly provided to a member by a licensed mental health provider, professional or paraprofessional.
- Nonresidential services for the treatment of nervous or mental disorders or substance use disorders provided to a member or the member's immediate family, if for the purpose of enhancing the member's treatment; services are provided by a licensed mental health provider, professional or paraprofessional.
- A program provided in an outpatient hospital or outpatient treatment facility.
- A covered dependent child who is a full-time student attending school will have coverage for limited outpatient services received from out-of-network providers for substance use disorders and mental and nervous disorders. This only applies to a dependent child without dependent wrap network coverage. This includes a clinical assessment of the problem. If outpatient services are recommended in the clinical assessment, not more than five visits to an out-of-network provider outpatient treatment facility or other provider will be covered. All out-of-network outpatient treatment facilities or providers must be in reasonable proximity to the school in which the student is enrolled. Prior authorization from Security Health Plan for all of these services is required before coverage is available as Security Health Plan may designate the provider who will provide these services.
    - If Security Health Plan determines that treatment will prevent the student from attending school on a regular basis or the student is no longer enrolled in school, out-of-network provider services will not be covered. Upon completing the five visits, coverage is not available for continuing care by the out-of-network provider unless approved by Security Health Plan. For purposes of this section, "school" means a vocational, technical and adult education school or any institution of higher education that grants a bachelor's or higher degree.

Limitations

- Inpatient and residential treatment require prior authorization. Other transitional outpatient services do not require prior authorization.
- If confined to an out-of-network hospital as an inpatient due to medical emergency, we reserve the right to coordinate your transfer to an in-network hospital once you are stable and can be safely moved.

- Notification is required for urgent or emergency inpatient hospital admissions. In accordance with Section Ins. 9.38 (4), Wis. Adm. Code, notification is required 48 hours after receiving services, or when it is medically feasible for the enrollee to provide the notice, whichever is later. Admission to another hospital is not covered when care is available at the in-network hospital where you were first admitted unless prior authorization is received.

Nutritional counseling and education visits

Covered

Nutritional counseling services by a registered dietitian when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of the treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Not covered

- Food or medical food formulated to be consumed or administered internally under the supervision of a physician intended for specific dietary management
- Nutritional supplements or vitamins

Office visits and outpatient care benefits

Covered

- Professional services provided in a licensed provider's office.
- Services provided in other outpatient settings when they are medically necessary and appropriate to diagnose or treat illness or injury.

Outpatient hospital and surgical services

Covered

- Outpatient hospital and ambulatory surgery center (ASC) services.
- Surgical services received from a licensed provider during an office visit, urgent care visit or outpatient hospital or ASC visit.
- Non-surgical outpatient hospital or ASC services received from or directed by a physician.
- Outpatient radiation oncology therapy.

Not covered

Take home prescription drugs and supplies dispensed at the hospital at the time of discharge for use at home, including discharge from emergency or urgent care visits, are not covered.

Limitations

Outpatient hospital and surgical services may require prior authorization. Please visit our website at www.securityhealth.org/authorization for a list of services or items requiring prior authorizations.

Prescription drug coverage

The formulary is regularly reviewed and updated. Most changes involve adding new drugs or drugs that are newly available in generic form. At times, drugs are removed from the formulary, change tier, or are moved to restricted status. To view the formulary go to www.securityhealth.org/prescription-tools or call Security Health Plan's Pharmacy Services Department at 1-877-873-5611.

Covered

- U.S. FDA-approved drugs included on the current formulary and obtained from an in-network pharmacy provider.
- Compound drugs not otherwise excluded under member's coverage and containing at least one FDA-approved drug for which Security Health Plan determines a commercially available alternative does not exist.
- Security Health Plan reserves the right to maintain a drug listing of medications that are not available/excluded for coverage per Plan medical necessity and limitation guidelines.
- Payment for excluded medications will be the Member's responsibility in full.
- Members may request an appeal (review of an Adverse Determination) based on medical necessity for Non-Covered medications. For details, refer to the appeals section of this Certificate of Coverage.

- Prescription medications identified as maintenance medications may be filled for a ninety (90) day supply, member responsibility depends on plan design
- If you are traveling on vacation and need an extra supply of medication, you may request a "vacation override" to receive up to a three (3) month's supply of medication. Vacation supplies are limited to the time period that the Member is enrolled in the plan and one vacation override per medication per calendar year. Contact Pharmacy Services to request a vacation override.

The Cancer Treatment Fairness Act:
Limits copayments to no more than $100 for a 30-day supply of oral chemotherapy. An ancillary charge will be assessed above and beyond the $100 monthly maximum for brand name prescription drugs where a generic is available. For high deductible health plans (HDHPs), the copay limit applies only after the member's deductible has been satisfied.

Not covered
- Prescription drugs not listed on current formulary unless a medical exception is granted.
- Drugs dispensed by out-of-network pharmacies except in cases of urgent or emergency care.
- Any drug without a valid prescription order unless mandated by state or federal government.
- Drugs that require a prior authorization, but a prior authorization was not obtained.
- Drugs recently approved by the FDA are either not covered or may change in coverage status until formally considered for formulary placement.
- Drugs not medically necessary.
- 75% of the prior dispensed amount remains or an accumulated ten days supply is on hand.
- Experimental or investigational drugs or medication usage pursuant to the Plan's medical coverage policies.
- Medications that may be received without charge under a government program, unless coverage is required for the medication.
- Medications that require professional administration (may include: intravenous (IV) infusion or injection, intramuscular (IM) injections, intravitreal (ocular) injection, intra-articular (joint) injection, intrathecal (spinal) injections) will apply to the Member's medical benefit.
- Replacement of a prescription medication due to loss, damage, or theft
- Lifestyle medications used to treat sexual dysfunction, impotence, or sexual inadequacy or to enhance sexual pleasure, intimacy or relationship.

Limitations
- Certain prescription drugs may require a prior authorization.
- Medical benefit drugs may require prior authorization (i.e. chemotherapy drugs).
- Certain prescription drugs may be subject to a quantity limit.
- Certain prescription drugs may have age restrictions.
- Specialty medications can be filled up to a thirty (30) day supply per copay (or less, if prescribed) at one time (unless otherwise approved by the Plan)..
- Select specialty prescription drugs will be limited to a number of partial fills to assess member tolerability and drug reaction prior to obtaining a one-month fill.
- Specialty prescription drugs may be limited to a designated specialty pharmacy.
- All prescription claims should be submitted electronically by the Pharmacy using your Security Health Plan pharmacy card. For prescription claims not submitted electronically by the Pharmacy, any dollar amounts in excess of the electronic contracted charge for that drug will not be covered.
- If you receive a brand name or reference drug when there is a generic equivalent or biosimilar available, you will be required to pay a penalty. The penalty consists of the price difference between the brand name/reference drug and the generic equivalent/biosimilar alternative, in addition to applicable cost sharing (copay and/or deductible/coinsurance) amounts. The penalty amount you pay does not apply to your deductible or maximum out of pocket.
- Certain drugs may require step therapy. If more than one prescription drug is determined to be safe and effective for the treatment of an illness or injury, we may only provide benefits for the less expensive prescription drug. Alternatively, we may require you to try the less expensive prescription drug before benefits are payable for any alternative prescription drug.
- Preventive drugs are limited to a generic equivalent when available.
- Authorized generic drugs may not be placed on the generic formulary tier. An authorized generic is the brand company's own product repackaged and marketed as a generic drug. An authorized generic is a brand-name drug.

- Generic drugs may not be placed on the formulary for coverage when a brand over generic strategy is in place. In these cases, the brand drug will be covered instead of the generic.
- Prescription drug coupon amounts are not applied to deductible and out-of-pocket limits.

Preventive care services

Services for preventive medical care can be provided on an outpatient basis at an in-network physician's office or a hospital. Security Health Plan covers all services required by the federal preventive mandate outlined in the Affordable Care Act. Consult your Schedule of Benefits or www.securityhealth.org/preventive for a list of the most common services.

Limitations

Age and diagnosis limits are based on a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Radiology and laboratory services

Covered

- Diagnostic x-rays and other imaging studies including but not limited to CT scans, PET scans, MRAs and MRIs when related to a covered physical illness or injury.
- Laboratory services received from an in-network laboratory provider when related to a covered physical illness or injury or to a preventive service.

Limitations

Radiology and laboratory services may require prior authorization. Please visit our website at www.securityhealth.org/authorization for a list of services or items requiring prior authorizations.

Skilled nursing facility care

Covered

- Daily skilled nursing facility care or daily skilled rehabilitation services including room and board.
- Physician and skilled physical therapy, speech therapy and occupational therapy when room and board is not eligible to be covered.
- Services and medical supplies received from a licensed provider during an inpatient stay in a skilled nursing facility.
- Hospital swing-bed confinement is considered the same as confinement in a skilled nursing facility.

Not covered

- Days away from the facility.
- Skilled nursing care at a skilled nursing facility if health care services can be provided at a lower level of care (e.g. home care).
- Custodial care and other non-skilled services.

Limitations

Skilled nursing facility care requires prior authorization. See your Schedule of Benefits for limits on the number of days per individual per confinement.

Telehealth and virtual care visits

Covered

Telemedicine/telehealth services provided through an in-network provider, including but not limited to:

- Behavioral health visits
- Care management visits
- Consultations
- Diabetes education visits
- Habilitative and rehabilitative therapy services, including occupational, physical and speech therapy
- Medication management visits
- Nutritional counseling
- Office visits

Not covered

- Connection fee
- Equipment required for a telehealth visit
- Email, fax or texting
- Appointment scheduling
- Prescription refill requests
- Reporting test results

Therapy services

Covered

- Medically necessary habilitative therapy services performed in an outpatient setting to help keep, learn or improve skills and functioning for daily living including:
    - Physical therapy
    - Occupational therapy
    - Speech-language pathology
    - Other services for people with disabilities.
- Medically necessary rehabilitative therapy services for treatment of an illness or injury, performed in an outpatient setting by a licensed therapist:
    - Physical therapy
    - Occupational therapy
    - Speech therapy
- Dry needling performed by a licensed provider is covered.

Not covered

The following are non-covered services but are not limited to:

- Rehabilitative services that are not for or related to the treatment of an illness or injury.
- Rehabilitative physical therapy, occupational therapy or speech therapy services where there is no reasonable expectation that your condition will improve over a predictable period of time according to generally accepted standards in the medical community.
- Rehabilitative services that continue after member reaches expected state of improvement, resolution or stabilization of health condition.
- Services an enrolled child's school is legally obligated to provide, whether or not the school actually provides them and whether or not the member chooses to use those services.
- Therapy services including:
    - recreational therapy
    - educational therapy
    - vocal therapy
    - group therapy
    - sports/physical fitness services enhancing physical condition.
- Work hardening.
- Functional capacity evaluation.
- Services related to non-covered items.
- Accent/dialect reduction and transgender voice change.
- Vocational and community reintegration services.
- Services performed in a school or home setting.
- Services provided by an athletic trainer.
- Acupuncture.

Limitations

- See your Schedule of Benefits for limits on the number of visits for habilitative and rehabilitative therapy.
- See your Schedule of Benefits for limits on the number of dry needling services.

Transplant services

Covered

Medically necessary solid organ, cellular therapy, gene therapy, blood and marrow transplant services are covered. Member is required to use a Center of Excellence (COE) facility that has met or exceeded quality standards for transplant care.

Not covered

- Lodging expenses including meals.
- Expenses related to the recipient's transportation except for medically necessary professionally licensed ambulance services.
- The purchase price of any bone marrow, organ or tissue that is sold rather than donated.
- Services not ordered by a physician or surgeon.
- Transplants involving non-human or artificial organs or tissues.
- Harvesting and storage of human tissue including but not limited to sperm, ovum and fetal cord blood.
- Potential donor testing.

Limitations

Services related to transplants, cellular therapy and gene therapy require prior authorization.

Urgent care services

Covered

Urgent care services from a licensed in-network or out-of-network provider are covered.

Not covered

Take-home prescription drugs and supplies dispensed by a hospital at the time of hospital discharge for use at home are not covered; this includes discharge from emergency or urgent care visits.

Limitations

Follow-up care must be received from an in-network provider, unless otherwise authorized by Security Health Plan or if the member's coverage, as defined in the Schedule of Benefits, covers out-of-network providers.

Vision services

Covered

- One routine eye exam per year including dilation/refraction for adults 19 and older, subject to member responsibility defined in the Schedule of Benefits.
- One routine eye exam per year including dilation/refraction and contact lens fitting until the end of the month the member turns 19.
- Non-routine adult vision services directly related to management of certain medical conditions, including but not limited to diabetes, glaucoma and retinal detachment.
- Visual impairment screening for children ages 1 thru 5.
- Standard intraocular lens after cataract surgery.
- First standard external lens or contact lenses after cataract surgery.
- Scleral shell contact lenses for the treatment of keratoconus.

Not covered

- Frames
- Eyeglass lenses or contact lenses except as defined in the Schedule of Benefits.
- Vision therapy (eye exercises training/orthoptics) and visual tracking training.
- Refractive eye (LASIK) surgery and other ocular procedures to improve refraction.
- Vision correcting intraocular lens after cataract surgery.
- Progressive lenses.
- Preparation or fitting eyeglasses or contact lenses and related fees for adults 19 and over.
- Eyeglass lenses or contact lenses except as defined in the Schedule of Benefits.

SECTION V – GENERAL EXCLUSIONS: WHAT'S NOT COVERED

In addition to specific exclusions and limitations identified in the "Member benefits" section and the Schedule of Benefits, coverage provides no benefits for the services listed below. Some of the listed exclusions may be medically necessary, but still are not covered under this plan. This list is not all-inclusive. Please refer to the Schedule of Benefits or contact Security Health Plan's Customer Service Department to find out whether a specific service will be covered.

Treatments

- Animal based therapy (hippotherapy).
- Coma stimulation.
- Complementary and alternative therapies.
    - Acupressure
    - Acupuncture
    - Aromatherapy
    - Art therapy
    - Dance therapy
    - Digital therapies (e.g. smart phone applications) except if offered to the member through Security Health Plan
    - Music therapy
    - Prolotherapy
- Cranial sacral therapy. (Massages intended to release tension and improve body movement.)
- Custodial or rest care. (Domiciliary care provided in a patient's home to assist with bathing, eating, cleaning and preparing meals; maintenance/supportive care.)
- Educational testing and training.
- Infertility. (All services related to restoring, enhancing or promoting fertility.)
- Foot care (routine). This includes the examination, treatment and removal of all or part of:
    - Corns.
    - Callosities.
    - Hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet.
    - The cutting, trimming or other non-operative partial removal of toenails.

  This exclusion does not apply to preventive foot care directly related to management of certain medical conditions, including but not limited to diabetes, neurological disease and vascular disease.
- Hair replacements or substitutions, including, but not limited to:
    - Wigs.
    - Prosthetic hairpieces.
    - Transplants and implants.
    - Hair restorations for any reason.
- Medical devices, appliances, durable medical equipment not listed on current formulary.
- Private-duty nursing.
- Psychosurgery.
- Rabies vaccine if no animal bite has occurred.
- Snoring treatment, medical and surgical, except when provided as part of treatment for documented obstructive sleep apnea.
- Weight loss interventions including surgery, drugs or diets, except nutritional counseling (see "Nutritional counseling and education visits" section).

Specific services

- Experimental and/or investigational services, and all related services are generally not covered.
- Indirect services provided by providers for services such as, but not limited to:
    - Creation of a laboratory's standards, procedures and protocols.
    - Calibrating equipment.
    - Supervising the testing.
    - Setting up parameters for test results.
    - And reviewing quality assurance data.
- Lab and therapy services associated with functional capacity evaluations/tests.

- Professional services not provided by a physician or any of the providers listed in the “Definitions” section of this Certificate.
- In all cases, Coordination of Benefits (COB) with Medicare will conform with federal and state statutes and regulations. For services that are covered by Medicare, if the member has or is eligible for Medicare, benefits will be coordinated to the extent benefits are or would be available from Medicare. This policy may be the primary or secondary payer with Medicare depending upon applicable state or federal laws and regulations.
- Services we conclude are not medically necessary. This includes services that do not meet our medical policy, clinical coverage or benefit policy guidelines.
- Services that are not for or related to the treatment of an illness or injury, except as specifically stated in coverage.
- Services that continue after the patient reaches the expected state of improvement, resolution or stabilization of a health condition.
- Services and charges for completing forms relating to such exams including but not limited to:
    - Exams for insurance
    - Employment
    - Adoption
    - Child support and custody evaluations
    - Immigration, licensing and certifications and/or
    - Settlement of lawsuits.
- Services from providers who are not in Security Health Plan’s provider network, except as specifically stated in the Certificate or Schedule of Benefits.
- Services provided or prescribed by the member’s immediate family, defined as a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with your same legal address.
- Services not specifically identified as being covered in the Certificate or Schedule of Benefits; services resulting or arising from complications of, or incidental to, any service not covered under the Certificate or Schedule of Benefits.
- Services for which proof of claim is not provided to Security Health Plan in accordance with the “Proof of claim” heading in Section VIII of this Certificate.
- Services provided in connection with any illness or injury caused by the member engaging in an illegal occupation or by the member’s commission of or an attempt to commit a felony, except for incidents involving domestic violence.
- Services provided in connection with any injury or illness arising out of, or in the course of, any employment for wage or profit for which an employer is required to carry workers’ compensation insurance. If the member is protected by workers’ compensation laws or any similar laws, this exclusion applies regardless of whether benefits under workers’ compensation laws or any similar laws have been claimed, waived or compromised, or whether the member is covered under workers’ compensation insurance. This exclusion also applies if the member self-represents in court, or retains an attorney, for disputed workers’ compensation claims. This exclusion does not apply to a sole proprietor or partner who elects not to become an employee, if Security Health Plan is provided with written proof of such election.
- Services furnished by the U.S. Veterans Administration, except for such services for which, under applicable federal law, the policy is the primary payer and the U.S. Veterans Administration is the secondary payer.
- Services covered by Medicare if the member has or is eligible for Medicare, to the extent benefits are or would be available from Medicare, except for such services for which, under applicable federal law, the policy is the primary payer and Medicare is the secondary payer.
- Services, such as public health services, furnished by any federal, state, county or city agency, or other similar entity, unless such coverage is required by any state or federal law.
- Treatment, services and supplies for illness or injury caused directly or indirectly by war, declared or undeclared, an act of war, enemy action or action while serving in the Armed Forces of any state or country, and benefits for such illness or injury are available under the laws of the United States or any political subdivision thereof. This includes illness or injury caused by atomic or thermonuclear explosion or resulting radiation; or any type of military action, friendly or hostile.

Pharmacy/prescription drug related

- Allergen extracts-sublingual drops.
- Appetite suppression/weight loss drugs (including those that have expanded indications with other disease states, e.g., obstructive sleep apnea, established cardiovascular disease).
- Compound medications:
    - Baclofen

    - Bromfenac
    - Bupivicaine
    - Cyclobenzaprine
    - Gabapentin
    - Ketamine
    - Ketoprofen
    - Orphenadrine
- Drugs applied, ingested or administered while member is a patient or resident in a:
    - Hospital
    - Outpatient provider setting
    - Mental health facility
    - Extended-care facility
    - Convalescent hospital
    - Skilled nursing facility
    - Hospice or similar institution.
- Drugs approved under the Federal Food and Drug Administration (FDA) Accelerated Approval Program, unless medically necessary or required by law.
- Drug Efficacy Study Implementation ("DESI") drugs
- Drugs used for cosmetic purposes, including hair growth.
- Drugs used for fertility treatment purposes.
- Medical Cannabis and/or its equivalents
- Medications and associated expenses and devices not approved by the FDA for a particular use except as required by law (unless Provider certifies off-label use with a letter of Medical Necessity)
- Orthomolecular therapy, including nutrients or vitamins unless otherwise specified as covered in this document
- Over-the-counter products not listed on the current formulary, including but not limited to:
    - drugs
    - dietary supplements
    - prenatal vitamins
    - other vitamins
    - medical foods
    - herbal preparations
    - bulk flavorings or colorants.
- Refills of any prescription older than one (1) year
- Self-administered medications dispensed in a Provider's office or non-retail pharmacy location
- Raw or bulk chemicals.
- Rrepackaged, commercially marketed prescription drug kits, unless specifically listed on the current formulary, that include:
    - Prescription drugs
    - Over-the-counter medications
    - Bulk chemicals
    - Durable medical supplies or
    - Any combination of these ingredients.
- Unit dose packaging
- Whole Blood and Blood Components Not Classified as Drugs in the United States Pharmacopoeia
- Wound dressings, dressings to regenerate tissue, non-medicated topical drugs hydrating or healing skin.

All other exclusions

- Allergy therapy and testing by methods that are not accepted as standard or approved by the American Academy of Allergy and Immunology or the U.S. Department of Health and Human Services or its offices or agencies.
- Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- Charges for missed appointments.
- Childcare fees.
- Costs for a non-medical facility or location for treatment, therapy or services provided outside a member's home.

- Court-ordered health care services or other services ordered by a court, except as specifically covered under this Certificate or Schedule of Benefits.
- Health clubs or health spas, aerobic and strength conditioning, health care services used in educational or vocational training, vocational rehabilitation, industrial rehabilitation, functional capacity evaluation, employment counseling, worksite and return-to-work evaluations, work hardening programs and all related material and products.
- Reimbursement of travel time for qualified:
    - Providers.
    - Supervising providers.
    - Professionals.
    - Therapists or qualified paraprofessionals.
- 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.
- Treatments that replicate or duplicate services provided by a school.

SECTION VI – WHEN MEMBERS HAVE MORE THAN ONE PLAN

How this applies to you

This section applies to this plan when a subscriber or a covered dependent has health care coverage under more than one plan. "Plan" is defined in Section XI Definitions.

The "Order of benefit determination rules" section below govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan.

The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

Order of benefit determination rules

General – When there is a basis for a claim under this plan and another plan, this plan is a secondary plan. That means this plan has its benefits determined after those of the other plan, unless those rules and this plan's rules described below require that this plan's benefits be determined before those of the other plan. Rules – this plan determines its order of benefits using the first of the following rules which applies:

- **Other plan with no rules** – If the other plan does not have rules coordinating its benefits with those of this plan, the benefits of the other plan are determined first.
- **Non-dependent/dependent** – The benefits of the plan that covers the person as an employee, member or subscriber are determined before those of the plan that covers the person as a dependent of an employee, member or subscriber.
- **Dependent child/parents not separated or divorced** – except as stated below, when this plan and another plan cover the same child as a dependent of different people, called "parents:" A parent can be any individual who serves as a policyholder including, but not limited to, legal guardians, step-parents and parents.
    - The benefits of the plan of the parent whose birthday falls earlier in the calendar year (month and day only) are determined before those of the plan of the parent whose birthday falls later in that calendar year.
    - But if both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.
    - However, if the other plan does not have the rules described above but instead has a rule based upon the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan shall determine the order of benefits.
- **Dependent child/separated or divorced parents** – If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
    - First, the plan of the parent with custody of the child.
    - Then, the plan of the spouse of the parent with custody of the child.
    - Finally, the plan of the parent not having custody of the child.
- Also, if the specific terms of a court decree state that the parents have joint custody and do not specify that one parent has responsibility for the child's health care expenses **OR** if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' plans have actual knowledge of those terms,
    - Benefits for the dependent child shall be determined according to dependent child/parents not separated or divorced.
- However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
- **Active/inactive employee** – The benefits of a plan that covers a person as actively employed are determined before those of a plan that covers that person as a laid-off or retired employee or as that employee's dependent. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. If a dependent is a Medicare beneficiary and if, under the Social Security Act of 1965 as amended, Medicare is secondary to the plan covering the person as a dependent of an active employee, the federal Medicare regulation will supersede this paragraph.
- **COBRA/Continuation coverage** – If a person has continuation coverage under federal or state law and is also covered under another plan, the following shall determine the order of benefits:

    - First, the benefits of a plan covering the person as an employee, member or subscriber or as a dependent of an employee, member or subscriber.
    - Second, the benefits under the continuation coverage.
- **Longer/shorter length of coverage** – If none of the above rules determines the order of benefits, the benefits of the plan that covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter time.

Effect on the benefits of this plan

When this subsection applies: This subsection applies when, in accordance with subsection "Order of benefit determination rules," this plan is a secondary plan as to one or more other plans. In that event, the benefits of this plan may be reduced under this subsection. Such other plan or plans are referred to as "the other plans."

Reduction in the plan's benefits: The benefits of this plan will be reduced when the total benefits payable exceeds the allowable expenses in a claim determination period. When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

Right to receive and release needed information

Security Health Plan has the right to decide which facts it needs to apply to these coordination of benefits (COB) rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these coordination of benefits rules. Medical records remain confidential as provided by federal and state law.

Each person claiming benefits under this plan must give Security Health Plan any facts we need to pay claims.

Facility of payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, Security Health Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it was a benefit paid under this plan. Security Health Plan will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefit is provided in the form of services.

Right of recovery

If the amount of the payments made by Security Health Plan is more than it should have paid under this section, it may recover the excess from one or more of:

- The people it has paid
- Insurance companies
- Other organizations

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Secondary payer

If covered expenses are incurred by a member who is eligible to apply for Medicare and for whom Medicare is primary, Security Health Plan will determine the benefits payable, if any, using the rules and regulations of Medicare in determining whether Medicare or Security Health Plan is primary. If Medicare is primary for a Medicare eligible member, the member is considered enrolled in and covered under Medicare Parts A and B, whether or not a member is actually enrolled in one or both parts of Medicare.

If a member for whom Medicare is primary and who is eligible to enroll in Medicare Part B, but fails to do so, or terminates their Medicare Part B coverage, we will still determine the benefits payable under the coverage as if that member had Medicare Part B coverage and Medicare paid Part B benefits, even if Medicare did not pay any Part B benefits. If a member does not elect Medicare Part B coverage, and Medicare Part B coverage would be primary, Security Health Plan will only pay 20% of Medicare's allowed amount, the difference is the member's responsibility.

To learn more about coordination of benefits and secondary payer, please visit http://www.cms.gov/medicare/coordination-benefits-recovery/overview/coordination-benefits.

Member responsibility

Members, including dependents, must notify Security Health Plan of Medicare eligibility, due to age or disability, as soon as possible so that benefits may be paid appropriately.

A member's relationship with a physician, hospital or other health care provider

Security Health Plan will not interfere with the professional relationship a member has with a health care provider. Security Health Plan does not contract with members to choose or provide a health care provider, services or facilities, nor do we assure their availability.

Security Health Plan is not responsible for any injury, damage or expense (including attorney fees) a member suffers as a result of any improper advice, action or omission of any health care provider. This includes, but is not limited to, any in-network health care provider. Security Health Plan is obligated only to provide the benefits stated in the coverage.

Continuity of care

If you are seeing an in-network health care provider and that provider's relationship with Security Health Plan ends, you may continue to see that provider. The provider will be treated as an in-network provider for the applicable period of time required by state law. The period of time depends on whether the provider is a primary care physician. If maternity care is being provided and you are in your second or third trimester of pregnancy when the relationship ends, care will be provided until the end of postpartum care of you and the infant. This paragraph does not apply if the provider no longer practices in the service area or if the provider's contract was terminated for misconduct.

If your provider's contract with Security Health Plan ends and you have any questions or concerns, please contact Security Health Plan Customer Service Department.

Assignment of benefits

This coverage is only for a covered employee and his or her covered dependents. Benefits may be assigned to the extent allowed by Wisconsin insurance laws.

Statement of rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and group health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than:

- 48 hours after a vaginal delivery
- 96 hours after a delivery by cesarean section.

However, the issuer may pay for a shorter stay if the attending provider (e.g., your physician, certified nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any late portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you might be required to obtain precertification. For information on precertification, contact Security Health Plan.

Maintaining high quality

Security Health Plan is dedicated to providing you with access to excellent, affordable and convenient health care services. Security Health Plan monitors the quality of care our members receive and makes sure new cost-effective alternatives meet high standards.

Security Health Plan is always looking for ways to make health care even better.

One proven way to do this is to listen to our members. If you have any ideas on how Security Health Plan can improve our services call Security Health Plan's Customer Service Department.

Health care provider, hospital or other health care provider reports

Physicians, hospitals and other health care providers must give Security Health Plan their records and reports to help Security Health Plan determine benefits due to a member and to otherwise administer a member's coverage. By applying for and accepting

coverage, members acknowledge that their health care providers may release medical records and reports to Security Health Plan for a member and all of a member's covered dependents. Members also waive any claims of privilege or confidentiality with respect to such information when used for the purposes described in this paragraph. This is a condition of Security Health Plan providing coverage to members and their covered dependents. It is also a continuing condition of Security Health Plan paying benefits.

In accordance with all state and federal laws, Security Health Plan may use individually identifiable information about a member to identify for a member (and the member alone) procedures, products or services that a member might find valuable. Security Health Plan will use individually identifiable information about a member as permitted or required by law. This includes in our operations and in our research. Security Health Plan will use de-identified data for commercial purposes including research.

Please refer to our Notice of Privacy Practices for details.

Incentives to health care providers

Security Health Plan pays in-network health care providers through various types of contractual arrangements. These may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect any member's access to health care.

Examples of financial incentives for in-network health care providers are:

- Bonuses for performance based on factors that might include quality, member satisfaction, and/or cost effectiveness.
- Capitation – a group of in-network health care providers gets a monthly payment from Security Health Plan for each member who selects an in-network health care provider within the group to perform or coordinate certain health services; the in-network health care providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the member's health care is less than or more than the payment.

Security Health Plan uses various payment methods to pay specific in-network health care providers. From time to time, the payment method may change. If a member has questions about whether an in-network health care provider's contract with Security Health Plan includes any financial incentives, Security Health Plan encourages that member to discuss those questions with his or her health care provider. The member may also contact us. Security Health Plan can tell a member whether a member's in-network health care provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to members

Sometimes Security Health Plan may offer coupons or other incentives to encourage members to participate in various health/wellness management programs. The decision about whether to participate is the member's alone, but Security Health Plan recommends that members discuss participating in such programs with their health care providers. These incentives are not benefits. These incentives do not alter or affect a member's benefits. Members may contact Security Health Plan Customer Service with any questions.

Rebates and other payments

Security Health Plan may receive rebates for certain drugs that members obtain from a pharmacy or are administered to members in their homes, in a health care provider's office, or at a hospital or alternate facility. This includes rebates for drugs that are administered to members before members meet any applicable annual deductible. Security Health Plan does not pass these rebates on to members, nor are they applied to any annual deductible or taken into account in determining members' copayments or coinsurance.

Other Security Health Plan coverage

Members may have coverage under more than one Security Health Plan policy. If so, benefits paid under all Security Health Plan policies combined will not exceed 100% of the total allowed amount for covered expenses.

Subrogation and workers' compensation

Workers' compensation

If benefits are inadvertently paid by Security Health Plan and we determine a member was eligible to receive workers' compensation benefits for the same incident, Security Health Plan has the right to recover as described under the "Right of subrogation and reimbursement" provision in this coverage. Security Health Plan may exercise our right to recover against a member or a member's covered dependents even though:

- The workers' compensation benefits are in dispute or are made by means of settlement or compromise.
- No final determination is made that bodily injury or sickness was sustained in the course of or resulted from the member's employment.
- The amount of workers' compensation due to medical or health care is not agreed upon or defined by the member or the workers' compensation carrier.
- Or the medical or health care benefits are specifically excluded from the workers' compensation settlement or compromise.

Members hereby agree that, in consideration for the coverage provided by this policy, they will promptly notify Security Health Plan of any workers' compensation claim they make. And agree to reimburse Security Health Plan as described below.

Right of subrogation and reimbursement
As soon as Security Health Plan pays or provides any benefits, it has the right to get back the money from anyone who might be responsible for paying a member because of injuries or damages. This includes all the benefits Security Health Plan gives under this coverage. "Responsible party" means anyone who might owe a member money or any insurance that might cover the payment, such as:

- Underinsured motorist insurance coverage
- Uninsured motorist insurance coverage
- Automobile medical payments or expenses coverage
- Automobile liability insurance coverage
- No-fault/personal injury protection coverage
- Workers' compensation coverage
- Homeowner liability insurance coverage
- Umbrella insurance coverage
- Patient compensation funds
- Any other first party insurance coverage
- Any other payments meant to compensate a member for injuries sustained or illness suffered

Security Health Plan is also granted a right of reimbursement from the proceeds of any settlement, judgment, arbitration award or other payment obtained by a member or a member's covered dependents from a responsible party as defined above. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted above, but only to the extent of the benefits paid by Security Health Plan. By virtue of any benefits paid, Security Health Plan is granted a lien on the proceeds of any settlement, judgment or other payment received by a member, and a member consents to said lien and agrees to take whatever steps are necessary to help Security Health Plan secure such lien.

Members will not assign any rights they might have to recover medical expenses from any potentially responsible party or other person to any minor child or children without the express consent of Security Health Plan. Our right to recover through subrogation or reimbursement shall apply to descendants, minors and incompetent or disabled persons' settlements or recoveries. Members must not make any settlement that specifically excludes or attempts to exclude the medical expenses paid by Security Health Plan.

Security Health Plan has the right to recover all payments it has made or will be obligated to pay in the future, to or on behalf of the member from anyone liable for the injury. If the member recovers from anyone liable for the injury, Security Health Plan will be reimbursed first from such recovery to the extent of Security Health Plan's payments to the member. The member agrees to assist Security Health Plan in preserving its rights against those responsible for such loss, and do nothing to prejudice Security Health Plan's right to recover.

Security Health Plan is entitled to reimbursement in full, and in first priority, regardless of whether:

- Any liability for payment is admitted by any potentially responsible party and
- The settlement or judgment received by a member identifies the medical benefits we provided.

Security Health Plan is entitled to recover the full amount of benefits paid without regard to any claim of fault on a member's part whether under comparative negligence or otherwise.

Security Health Plan is entitled to recover from any and all settlements or judgments. This includes those designated as "pain and suffering" or "non-economic damages only." The proceeds of any settlement, judgment, award or other payment recovered by a member must be allocated first to full reimbursement of our payments. This recovery may be modified accordingly if required by an applicable state law ("Made whole" or "Rimes" doctrine) that holds an insurance company may not enforce a right of subrogation or reimbursement until the insured party has been fully compensated for any injuries. Once Security Health Plan has been reimbursed for the medical expenses we paid, the rest of the judgment or settlement amount can be paid out to the member or the member's dependent(s).

Collection costs and attorney fees
The member will not incur any expenses on our behalf including, but not limited to, court costs or attorney's fees, without our prior express written consent. Our right to full reimbursement will not be reduced because of any so-called "Fund Doctrine," "Common Fund Doctrine," "Attorney's Fund Doctrine," or any other law which implies our agreement or otherwise requires Security Health Plan to pay, or to accept as reimbursement in kind, any amount or share of attorney's fees or other services or expenses incurred by a member or a member's dependents in obtaining a judgment, settlement or other payment from a third party.

If Security Health Plan has to take legal or other action to enforce our lien or to be reimbursed by a member or a member's dependents, the member or the member's dependents may also be required to reimburse Security Health Plan for the costs we had to pay to collect the amount the member owed, including our attorneys' fees.

Your cooperation required
When you receive treatment for an accident or injury you will receive an inquiry letter asking for the details of the accident. The inquiry must be completed in full, signed, and dated within 30 days for Security Health Plan to process your claims. If the inquiry is not returned within 30 days, claims will be denied. A completed inquiry received within one year from the date of the original inquiry will result in previously denied claims to be reprocessed.

Neither you nor your dependents shall do anything to prejudice our subrogation and reimbursement rights. You shall not enter into a settlement or compromise agreement with a responsible party without our prior written consent. You shall, when requested, fully cooperate with our efforts to recover the benefits Security Health Plan paid. You shall promptly notify Security Health Plan when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages, due to injuries sustained by you. You shall include the benefits paid by Security Health Plan as part of the damages you are seeking to recover in any claim or legal action you file against the potentially responsible party who caused the injury or illness. You further agree to contact Security Health Plan to resolve our lien prior to any settlement or following any verdict, judgment or award.

If a member or member's dependents receive a recovery to which our lien applies, Security Health Plan maintains the right to offset benefit payments on any other claim made by a member or member's dependents until the reimbursement is paid in full. Security Health Plan may further require that a member or member's dependents sign an agreement guaranteeing our right to subrogation and reimbursement before it provides any further benefits to or on behalf of your dependent. Further, no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and Security Health Plan is not required to participate in or pay court costs or attorneys' fees to the attorney hired by a member to pursue a member's damage/personal injury claim.

Members hereby agree that, in consideration for the coverage given by this policy, members will promptly notify Security Health Plan of any claims they make and that members agree to reimburse Security Health Plan as described above.

Failure to cooperate with our subrogation or reimbursement processes may result in denial of claims.

Limitation on lawsuits and legal proceedings

No member may bring any legal action against Security Health Plan regarding benefits or claims submitted, or any other matter concerning his/her coverage until the earlier of:

- 60 days after Security Health Plan has received or waived proof of claim; or
- The date Security Health Plan denies payment of benefits for a claim. Action can be brought earlier if waiting will result in prejudice against a member. However, the mere fact that a member has to wait until the earlier of the above is not

considered prejudicial. No action can be brought more than three years after the time Security Health Plan requires written proof of claim. See “Proof of claim” subsection.

Severability
Any term, condition or provision of the contract prohibited by Wisconsin law shall be void and without force or effect. But this will not invalidate the enforceability of any other term, condition or provision of the contract.

Conformity with laws of the State of Wisconsin
On the effective date of the coverage, any provision conflicting with Wisconsin law shall automatically conform to the minimum requirements of such laws. If any state or federal laws cited in this coverage are amended, the coverage will be read to conform to the amended law.

Entire contract
The entire contract providing coverage to the member is made up of the Policy, including the policyholder’s application, the Certificate, Schedule of Benefits, any amendments, the member’s application and any supplemental applications.

Waiver and change
Only the Security Health Plan chief executive officer (CEO) or someone they choose can approve a waiver or change the coverage. No agent, broker or anyone else can change any part of the plan or extend the time to pay premiums. Security Health Plan can change any term, condition, exclusion, limitation or other part of the coverage if Security Health Plan sends written notice to the policyholder at least 30 days before the change. If the change reduces coverage, Security Health Plan must send written notice at least 60 days before the change takes effect. Each amendment applies to subscribers, members and Security Health Plan. No mistake, including clerical errors, will cancel valid coverage, continue or reissue ended coverage or cause coverage to be issued that otherwise would not be issued by Security Health Plan. When we discover an error, Security Health Plan will make a fair adjustment of coverage, payment of benefits and/or premium.

Interpretation of benefits
Security Health Plan has the sole and exclusive discretion to do all of the following:

- Interpret benefits under the coverage
- Interpret the other terms, conditions, limitations and exclusions set out in the coverage, including this Certificate, the Schedule of Benefits, and any riders and/or amendments
- Make factual determinations related to the coverage and its benefits

Security Health Plan may delegate this discretionary authority to other people or entities that provide services in regard to the administration of the coverage.

In certain circumstances, for purposes of overall cost savings or efficiency, Security Health Plan may, in our discretion, offer benefits for services that would otherwise not be covered. The fact that Security Health Plan does so in any particular case shall not in any way be deemed to require Security Health Plan to do so in other similar cases.

Administrative services
Security Health Plan may, in our sole discretion, arrange for various people or entities to provide administrative services in regard to the coverage, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. Security Health Plan is not required to give a member prior notice of any such change, nor are we required to obtain a member’s approval. A member must cooperate with those people or entities in the performance of their responsibilities.

Amendments to the coverage
To the extent permitted by law, Security Health Plan reserves the right, in our sole discretion and without a member’s approval, to:

- Change
- Interpret
- Modify
- Withdraw or add benefits
- Terminate the coverage.

Any provision of coverage that, on its effective date, conflicts with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations. No other change may be made to the coverage unless it is made by an amendment or rider that has been signed by one of our officers. All of the following conditions apply:

- Amendments to the coverage are effective upon written notice to the member, unless otherwise specified in the amendment.
- Amendments that result in reduced benefits will be effective upon 60 days' prior written notice.
- Riders are effective on the date Security Health Plan specifies.
- No agent has the authority to change the coverage or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the coverage.

Limit on certain defenses

After two years have passed from a member's effective date of coverage, no misstatement will be used to void a member's coverage or deny benefits for any claim. This does not apply to fraudulent misstatements made in a member's application.

Direct payments and recovery

Direct payment of benefits

Unless otherwise stated in the coverage, Security Health Plan can pay benefits either directly to the health care provider or to the member. Such payments will fully discharge Security Health Plan from all further liability to the extent of benefits paid.

Recovery of excess payments

If Security Health Plan pays more benefits than we are liable for under the coverage including, but not limited to, benefits paid in error, we can recover them from any person, organization or health care provider that has received such excess benefit payments. Security Health Plan can also recover such payments from any other insurance company, service plan or benefit plan that has received them. If Security Health Plan cannot recover them from another source, we can also recover them from the member. When we request that the member pay Security Health Plan an amount of the excess benefit payments, the member agrees to pay Security Health Plan such amount as specified in the request.

Security Health Plan may, at our option, reduce any future benefit payments for which we are liable on our claims by the amount of the excess benefit payments to recover such payments. Security Health Plan will reduce benefits otherwise payable for such claims until we recover the excess benefit payments.

Claims submission and processing

When receiving services, it is your responsibility to notify providers of your enrollment in the Health Plan to ensure claims are submitted and processed under your Health Plan coverage.

When receiving services from an in-network provider they will send us a claim on your behalf. Failure to notify an in-network provider of your enrollment with the Health Plan may result in claims not being submitted within the required timeframe. This could result in the claim being denied or a delay in the claim being paid and member cost share amounts being billed to you by the provider.

Proof of claim

If you receive covered services from an out-of-network provider, they may submit a claim on your behalf or they may ask you to pay for services out of your pocket. If you pay for services out of your pocket you may submit a claim to us for reimbursement. In order to be reimbursed you must submit a Proof of Claim, including at a minimum:

- Full name and date of birth and/or Subscriber ID
- The dates the services were received
- An itemized bill from the provider which includes:
    - A detailed listing of services received
    - Billed amounts for each service
    - Provider's name and address
    - The specific medical condition or symptom diagnosed
- Proof of payment (can be a paid receipt or invoice from the provider showing services were paid in full)
- If the services were received outside the United States, indicate the appropriate exchange rate at the time the services were received and provide an English language itemized bill

The above information should be submitted within 15 months from the date the services were performed. In accordance with Wisconsin law, if circumstances beyond your control prevent you from submitting such proof to Security Health Plan within this time period, Security Health Plan will accept a claim, if provided as soon as possible and within one year after the 15-month period. If Security Health Plan does not receive the written proof of claim required by Security Health Plan within that one-year-and-15-month period, no benefits are payable for that service.

Proof of claim information should be submitted via mail, fax or email to:
Security Health Plan
Attn: Claims
P.O. Box 8000
Marshfield, WI 54449
Fax: 715-221-9767
Email: rf.shpmain@securityhealth.org

A claim will be treated as received by Security Health Plan (a) on the date it is hand-delivered to Security Health Plan at the indicated address; or (b) on the date that it is received by the health plan. Claims must be submitted by the applicable deadlines for the type of claim as indicated in these procedures. Unless otherwise indicated, when used in these claims procedures, the term "day" means a calendar day.

Once claims are processed you will receive an Explanation of Benefits from us indicating how services were covered and any cost-sharing amounts you may be responsible for.

Designating an authorized representative

An authorized representative may act on behalf of a claimant with respect to a benefit claim or appeal under these claims procedures. No person (including a treating health care professional) will be recognized as an authorized representative until Security Health Plan gets a written request signed by the claimant, except that for urgent care claims, when Security Health Plan will, even in the absence of a written request, recognize a health care professional with knowledge of the claimant's medical condition (e.g., the treating physician) as the claimant's authorized representative unless the claimant provides specific written direction otherwise.

Written requests must be submitted to Security Health Plan at the address indicated under "Filing a claim." Once an authorized representative is appointed, Security Health Plan will direct all information, notification, etc. regarding the claim to the authorized representative. The claimant shall be copied on all notifications regarding decisions, unless the claimant provides specific written direction otherwise. Where appropriate, references in these claims procedures to claimant include the claimant's authorized representative.

An assignment for purposes of payment (e.g. to a health care professional) does not constitute appointment of an authorized representative under these claims procedures.

Special filing rules for certain claim types

Post-service claims: A post-service claim must be filed within 90 days following receipt of the medical service, treatment, prescription drug or product to which the claim relates unless:

- It was not reasonably possible to file the claim within such time.
- And the claim is filed as soon as possible and in no event (except in the case of legal incapacity of the claimant) later than one year beyond the end of the 90-day period for filing a claim.

All prescription drug claims not submitted electronically will be reimbursed at the electronic, contracted rate; not necessarily the dollar amount paid to the pharmacy.

Incorrectly filed claims: These claims procedures do not apply to any request for benefits that is not made in accordance with these claims procedures, except that:

- In the case of an incorrectly filed pre-service claim, the claimant shall be notified as soon as possible but no later than 5 days following receipt by Security Health Plan of the incorrectly filed claim.
- And in the case of an incorrectly filed urgent care claim, the claimant shall be notified as soon as possible but no later than 24 hours following receipt by Security Health Plan of the incorrectly filed claim.

The notice shall explain that the request is not a claim and describe the proper procedures for filing a claim. The notice may be oral unless written notice is specifically requested by the claimant.

Incomplete claims: If any information needed to process a claim is missing, the claim shall be treated as an incomplete claim.

Incomplete urgent care claims: If an urgent care claim is incomplete, Security Health Plan shall notify the claimant as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notification may be made orally to the claimant unless the claimant requests written notice. The notification will describe the information necessary to complete the claim and specify a reasonable time, no less than 48 hours, within which the claim must be completed. Security Health Plan shall decide the claim as soon as possible but not later than 48 hours after the earlier of:

- Receipt of the specified information.
- Or the end of the period of time provided to submit the specified information.

Other incomplete claims: If a pre-service or post-service claim is incomplete, Security Health Plan may deny the claim or may take an extension of time, as described below. If Security Health Plan takes an extension of time, the extension notice shall include a description of the missing information and shall specify a period, of no less than 45 days. Within that time the necessary information must be provided. The time frame for deciding the claim shall be suspended from the date the extension notice is received by the claimant until the date the missing necessary information is provided to Security Health Plan. If the requested information is provided, Security Health Plan shall decide the claim within the extended period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

Grievance procedure

General process

Situations might occasionally arise when a member questions or is unhappy with some aspect of service received under this plan. Because most questions about benefits and plan operations can be resolved on an informal basis, Security Health Plan urges members first to try to resolve any problem by directly contacting the appropriate health care provider or by calling Security Health Plan's Customer Service Department at 1-800-472-2363 TTY 711.

A member (or anyone else on a member's behalf) has the right to file a formal grievance with Security Health Plan. Security Health Plan will continue the member's coverage pending the outcome of any grievance that uses this process.

A member also has the right to appeal an adverse benefit determination. Every time Security Health Plan makes an adverse benefit determination, we will notify the member of his or her right to file a grievance. These procedures are the only means through which an adverse benefit determination may be appealed.

Security Health Plan must strictly adhere to all the procedures in this section. The member may, at the member's expense, have legal representation at any stage of these grievance procedures.

How to file a grievance

To file a grievance, the member (or anyone else on the member's behalf) should write down their concerns and mail or deliver to Security Health Plan, the grievance (in any form) along with copies of any supporting documents, including any written comments or information to support the grievance.
Mailing Address: Section 504 Coordinator, 2301 E. 60th Street, Sioux Falls, SD 57103
Telephone Number: (877) 473-0911 (TTY: 711)
Fax: (605) 312-9886
Email: shp.appeals.grievance@securityhealth.org

Except for expedited grievances, including for urgent care claims, as discussed below, Security Health Plan will acknowledge a grievance in writing within five business days of its receipt. The member will receive a written confirmation of the Appeals and Grievance Committee meeting date a minimum of 7 days before the meeting is scheduled.

How grievances will be decided

At the meeting, the member and/or the member's authorized representative have the right to attend and present information relevant to the grievance through a conference call. The Appeals and Grievance Committee will review the grievance and all relevant documents pertaining to the grievance, whether or not presented or available at the time of the initial decision. The

committee discussion will not include the person who made the initial determination or any of that person's subordinates. The committee will then make a decision on the resolution of the grievance.

In the case of a claim decided on the grounds of medical judgment, the committee may consult with a health professional with appropriate training and experience. The health care professional who is consulted by the committee will not be the same individual who was consulted regarding the initial decision. It will also not be a subordinate of that individual.

The member shall, on request and free of charge, be given reasonable access to, and copies of, all information relative to the grievance:

- Documents.
- Records.
- Other information relevant to the grievance.

If the advice of a medical or vocational expert was obtained in connection with the initial decision, the names of each such expert shall be provided to the member at their request, regardless of whether the advice was relied on by Security Health Plan. Before issuing a final decision on the grievance that is based on a rationale that was not included in the initial determination, Security Health Plan will provide the member, free of charge, with the rationale as soon as possible and sufficiently in advance of the final decision to give the member a reasonable opportunity to respond.

Expedited grievance
A grievance where any of the following applies:

- The duration of the standard resolution process will result in serious jeopardy to the member's life, health or recovery.
- In the opinion of a physician with knowledge of the member's condition, the member is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.
- A physician with knowledge of the member's condition determines that the grievance should be treated as an expedited grievance.

In addition, any appeal of an urgent care claim shall be treated as an expedited grievance. In situations where the normal duration of the grievance process could have adverse effects on the member, an expedited grievance will not need to be submitted in writing. Instead, the member or the member's physician should contact Security Health Plan as soon as possible.

Supporting documents may be submitted to Security Health Plan's Quality Department via fax at 715-221-9424. Security Health Plan will resolve the expedited grievance within 72 hours of its receipt, unless more information is needed. If more information is needed, Security Health Plan will notify the member of our decision by the end of the next business day after the receipt of the required information. The grievance process for urgent situations does not apply to prescheduled treatments, therapies, surgeries or other procedures that Security Health Plan does not consider urgent situations.

Timing of decisions
In general – Except for appeals of adverse benefit determinations described in this section, "Timing of decisions," Security Health Plan will resolve all grievances within 30 calendar days of receipt. If Security Health Plan is unable to resolve the grievance within that time, we will send written notification before the 30-day period has expired, indicating more time is needed. This will explain the reason more time is needed and the expected date it will be resolved.

Expedited grievances and urgent care claims – Security Health Plan shall decide the appeal of an expedited grievance or urgent care claim as soon as possible, taking into account medical needs. This will be no later than 72 hours after receipt of the expedited grievance.

Pre-service claims – Security Health Plan shall decide the appeal of a pre-service claim within a reasonable time appropriate to the medical circumstances. This will be no later than 30 days after receipt by the Plan.

Post-service claims – Security Health Plan shall decide the appeal of a post-service claim within a reasonable period. This will be no later than 30 days after receipt.

Concurrent care claims – Security Health Plan shall decide the appeal of a decision to reduce or terminate an initially approved course of treatment (see the definition of concurrent care decision) before the proposed reduction or termination takes place.

Security Health Plan shall decide the appeal of a denied request to extend any concurrent care decision in the appeal timeframe for pre-service, urgent care or post-service claims described above, as appropriate to the request.

Notification of decision
After a member's grievance is reviewed, the member will receive a written notification of the committee's decision, whether or not the decision is adverse. The written notice will always include the titles of the people on the Appeals and Grievance Committee.

If a member's grievance is denied, in whole or in part, Security Health Plan will send the member a notice, in writing, written in a manner to be understood by you (including, if necessary, in a culturally and linguistically appropriate manner according to applicable requirements) that includes:

- The specific reason(s) for the decision;
- Information sufficient to identify the claim or issue involved such as the date of service, the health care provider, the claim amount, the diagnosis code and its meaning, and the treatment code and its meaning;
- The denial code and its meaning, which is a description of the standard that was used to deny the claim;
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- A reference to the specific provision(s) in the policy on which the decision is based;
- A description of available external review processes;
- A statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination;
- Any information the member needs to perfect the claim or issue;
- If the decision involves scientific or clinical judgment, either (a) an explanation of the scientific or clinical judgment applying the terms of policy to the claimant's medical circumstances; or (b) a statement that such explanation will be provided at no charge on request;
- A statement of the right to sue in federal court; and
- Notification of an adverse determination on appeal of an urgent care claim may be provided orally, but written notification shall be furnished no later than three days after the oral notice.

Office of the Commissioner of Insurance
You may resolve your problem by taking the steps outlined in your HMO grievance procedure. You may also contact the Office of the Commissioner of Insurance, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the Office of the Commissioner of Insurance at its website at http://oci.wi.gov/, or by writing to:

Office of the Commissioner of Insurance Complaints Department
P.O. Box 7873
Madison, WI 53707−7873

Or you can call 1−800−236−8517 or 608-266−0103 and request a complaint form.

Office for Civil Rights
For grievances based on race, color, national origin, sex or age discrimination you may also contact the U.S. Department of Health and Human Services, Office for Civil Rights. You can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, TDD 1-800-537-7697

Such complaints must be filed within 180 days of the date of the alleged discrimination.

External review program

If Security Health Plan denies the member's internal appeal of an adverse benefit determination, then the plan will issue the member a final adverse benefit determination. This means that Security Health Plan believes our original denial of the member's claim or service was right.

If the member gets a final adverse benefit determination, then the member can request an independent external review of Security Health Plan's decision from the federal external review program administered by the U.S. Department of Health and Human Services.

The member should file a request for external review within four months of the date the member gets the final adverse benefit determination. If there is no corresponding date four months after the date of receipt of final adverse benefit determination, then the request must be filed by the first day of the fifth month following the receipt of the final adverse benefit determination. If the last filing date would fall on a Saturday, Sunday or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or federal holiday.

External review requests are to be submitted in writing. The member may obtain the contact information for the current certified Independent Review Organization (IRO) by calling Security Health Plan's Customer Service Department.

The request should contain:

- Name
- Address
- Phone number
- Email address (if any)
- Whether the request is urgent
- The reason for disagreement with decision
- Any documents that support member's position
- A statement authorizing member's representative to pursue the external review on member's behalf (if member chooses to use one)
- The member's signature if the person filing the appeal is not the member

The IRO will contact Security Health Plan once it gets the request for external review. Within five business days following the date it gets an external review request, Security Health Plan will send the IRO all the documents and information used to make the final adverse benefit determination.

Upon receipt of the member's request, the IRO will notify the member in writing of their request's eligibility and acceptance for external review. In general, an adverse benefit determination is eligible for external review if it involves:

- Medical necessity
- Appropriateness
- Health care setting
- Level of care
- Effectiveness of a covered benefit
- Whether a treatment is experimental or investigational
- Any other matter that involves medical judgment
- Rescissions of coverage

If the IRO determines the request is not eligible for external review, they will notify the member and Security Health Plan and the external review will terminate.

Review by Independent Review Organization

If the request is eligible for review, the IRO will review all the information and documents it gets. It will review Security Health Plan's decision independent of any decision or conclusions reached by Security Health Plan as part of its internal appeals process.

After the member submits their request, they may submit additional information in writing to the IRO at any time before they make their final decision. The IRO will forward any additional information submitted to Security Health Plan.

If, on the basis of any additional information submitted, Security Health Plan reconsiders the case and decides that the claim or service should be covered, then Security Health Plan will send the member and the IRO a notice in writing of that decision and the external review is terminated.

The IRO will give written notice of its final decision to the member and to Security Health Plan within 45 days after they get the request for external review. If the IRO gives written notice to Security Health Plan that it is reversing the final internal adverse benefit determination, Security Health Plan will immediately notify the member in writing of the timeframe and procedure for payment of the claim or approval of the requested service.

Expedited review
An adverse benefit determination is eligible for an expedited external review if it involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the member's life, health or ability to regain maximum function and if they have filed a request for an expedited internal appeal.

A final adverse benefit determination is eligible for an expedited external review if it involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the member's life or health or would jeopardize the member's ability to regain maximum function, or if the final internal adverse benefit determination concerns:

- An admission.
- Availability of care.
- Continued stay.
- Or health care item or service for which the member received emergency services, but has not been discharged from a facility.

If the IRO gets a request for an expedited external review, it will immediately notify Security Health Plan of the request. The IRO will determine whether the request is eligible for expedited external review. If the request is not eligible for expedited external review, then the IRO will notify the member and Security Health Plan as quickly as possible. If the request is eligible for expedited external review, Security Health Plan will immediately submit to the IRO all the documents and information contained in the member's appeal file and all other information that was used for the adverse benefit determination or the final adverse benefit determination.

The IRO will give notice of its final decision as quickly as the member's medical condition or circumstance requires. It will not be more than 72 hours after the IRO gets the request for an expedited external review. If the notice is not in writing, within 48 hours after the date it gave the notice, the IRO will give written confirmation of that decision to the member and to Security Health Plan.

SECTION IX – NOTICE OF NONDISCRIMINATION/LIMITED ENGLISH PROFICIENCY SERVICES

Discrimination is against the law
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, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation in the administration of the plan, including enrollment and benefit determinations.

Security Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at (800) 472-2363 (TTY: 711). If you believe that Security Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military, you can file a grievance with a The Section 504 Coordinator at:

Security Health Plan
Attn: Section 504 Coordinator
2301 E. 60th Street
Sioux Falls, SD 57103
Phone: (877) 473-0911 (TTY :711) Fax: (605) 312-9886
Email: shp.appeals.grievance@securityhealth.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Security Health Plan Section 504 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
Phone: 1-800-368-1019 (TDD 800-537-7697)
More information is available at http://www.hhs.gov/ocr/index.html.

Limited English Proficiency Language Services

English: ATTENTION: Free interpretation services are available to you. Additional services and resources necessary to provide information on accessible formats are also available at no cost. Call (800) 472-2363 (TTY: 711) or speak with your provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al (800) 472-2363 (TTY: 711) o hable con su proveedor.

Hmong: LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau (800) 472-2363 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

Oromo: HUBADHAA: Yoo afaan Oromoo dubbattu ta'e, tajaajilli gargaarsa afaanii bilisaa siniif ni argama. Gargaarsi gargaaraa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama. Bilbilaa (800) 472-2363 (TTY: 711) yookiin dhiyeessaa kee waliin haasa'aa.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie (800) 472-2363 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Amharic: ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር (800) 472-2363 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số (800) 472-2363 (Người khuyết tật 711) hoặc trao đổi với người cung cấp dịch vụ của bạn."

Pennsylvania Dutch: WICHDICH: Wann du Deitsch schwetzscht un brauchscht Hilf fer eppes verschtehe, kenne mer dich helfe unni as es dich ennich eppes koschde zellt. Mir kenne dich en latt differnti Sadde Schprooch-Hilf bei griege, so as du Information in differnti Wege verschtehe kannscht, aa fer nix. Call (800) 472-2363 (TTY: 711) odder schwetz mit dei Provider.

Simplified Chinese: 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 (800) 472-2363（文本电话：711）或咨询您的服务提供商。

French: ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le (800) 472-2363 (TTY: 711) ou parlez à votre fournisseur.

Nepali: सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। (800) 472-2363 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

Burmese: သတိပြုရန်- သင်က မြန်မာဘာသာစကား ပြောဆိုပါက၊ အခမဲ့ ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုများကို ရနိုင်ပါသည်။ အသုံးပြုနိုင်သော ဖော်မတ်များဖြင့် အချက်အလက်များ ဖော်ပြပေးရန် သင့်လျော်သော အရန်အကူအညီများနှင့် ဝန်ဆောင်မှုများကိုလည်း အခမဲ့ ရရှိနိုင်ပါသည်။ (800) 472-2363 (TTY: 711) သို့ဖုန်းခေါ်ပါ သို့မဟုတ် သင်၏ ဆောင်ရွက်ပေးသူနှင့် စကားပြောပါ။

Arabic:

نبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 2363-472 (800) (TTY: 711) أو تحدث إلى مقدم الخدمة.

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa (800) 472-2363 (TTY: 711) o makipag-usap sa iyong provider.

Swahili: MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu (800) 472-2363 (TTY: 711) au zungumza na mtoa huduma wako.

Karen: ဆူ– နမ့ၢ်ကတိၤ ထၢနှာ်လီၤဖဲအံၤ အဃိ, တၢ်အိဉ်ဒီး ကျိဉ်တၢ်ဆီဉ်ထွဲမၤစၢၤ လၢတလၢ် ဘူဉ်လၢ်စ့ၤလၢနဂီၢ်လီၤ. တၢ်အိဉ်ဒီး တၢ်မၤစၢၤတၢ်နှၢ်ဟူဝီးလီဒီး တၢ်မၤစၢၤတၢ်မၤ လၢအ ကြၢးအဘဉ် လၢကဟ့ဉ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤနှၢ်အီၤသ့တဖဉ် လၢတလၢ်ဘူဉ်လၢ်စ့ၤ လၢနဂီၢ်လီၤ. ကိး (800) 472-2363 (TTY: 711) မ့တမ့ၢ် ကတိၤတၢ်ဒီး နပှၤလၢဟ့ဉ် နၤတၢ်ကွၢ်ထွဲမၤစၢၤတက့ၢ်.

Yoruba: ÀKÍYÈSI: Tí o bá lè sọ èdè Yorùbá, àwọn ètò ìrànlọ́wọ́ èdè wà lọ́fẹ̀ẹ́ fún ọ. A ó tún pèsè àwọn ohun èlò ìrànlọ́wọ́ àti àwọn iṣẹ́ tó bá yẹ láti pèsè ìsọfúnni nípa àwọn ọ̀nà tí ó rọrùn láti lóye lọ́fẹ̀ẹ́. Pe (800) 472-2363 (TTY: 711) tàbí kí o bá olùpèsè rẹ sọ̀rọ̀.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। (800) 472-2363 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Polish: UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer (800) 472-2363 (TTY: 711) lub porozmawiaj ze swoim dostawcą.

Russian: ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону (800) 472-2363 (TTY: 711) или обратитесь к своему поставщику услуг.

Brazilian Portuguese: ATENÇÃO: Se você fala Português do Brasil, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para (800) 472-2363 (TTY: 711) ou fale com seu provedor.

Korean: 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. (800) 472-2363 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Somali: FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac (800) 472-2363 (TTY: 711) ama la hadal bixiyahaaga.

Laos: ຊຶນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ (800) 472-2363 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

Large print – If you require materials in large print, please call (800) 472-2363 (TTY: 711).

SECTION X – HOW SECURITY HEALTH PLAN PROTECTS YOUR PRIVACY

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") applies to Sanford Health Plan and Security Health Plan. If you have questions about this Notice, please contact Sanford's Privacy Office at (800) 325-9402. You may also email your questions to privacyoffice@sanfordhealth.org.

This Notice describes how we will use and disclose your health information. The terms of this Notice apply to all health information generated or received by Sanford Health Plan and Security Health Plan, whether recorded in our business records, your medical record, billing invoices, paper forms, or in other ways. Unless otherwise provided by law, any data or information pertaining to the health, diagnosis, or treatment of a member under a policy or contract, or a prospective member, obtained by Sanford Health Plan or Security Health Plan from that person or from a health care provider is confidential and may not be disclosed except as set forth below.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We use or disclose your health information as follows (In Minnesota we will obtain your prior consent):

- **Help manage the health care treatment you receive:** We can use your health information and share it with professionals who are treating you. For example, a doctor may send us information about your diagnosis and treatment plan so we can arrange additional services.
- **Pay for your health services:** We can use and disclose your health information for the payment of your health services. For example, we share information about you with your provider to coordinate payment for those services.
- **For our health care operations:** We may use and share your health information for our day-to-day operations, to improve our services, and contact you when necessary. For example, we use health information about you to develop better services for you. We may also use and disclose your protected health information to determine premium costs, underwriting, rates and cost-sharing amounts, provided that no genetic information may be used for underwriting purposes. This does not apply to long-term care plans.
- **Administer your plan:** We may disclose your health information to your health plan sponsor for plan administration. For example, your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

We may share your health information in the following situations unless you tell us otherwise. If you are not able to tell us your preference, we may go ahead and share your information if we believe it is in your best interest or needed to lessen a serious and imminent threat to health or safety:

- **Friends and Family:** We may disclose to your family and close personal friends any health information directly related to that person's involvement in payment for your care.
- **Disaster Relief:** We may disclose your health information to disaster relief organizations in an emergency.

We may also use and share your health information for other reasons without your prior consent:

- **When required by law:** We will share information about you if State or federal law require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. This may include disclosing information about victims of abuse, neglect, or domestic violence.
- **Law enforcement:** We may share information for law enforcement purposes. This includes sharing information to help locate a suspect, fugitive, missing person or witness.
- **For public health and safety:** We can share information in certain situations to help prevent disease, assist with product recalls, report adverse reactions to medications, and to prevent or reduce a serious threat to anyone's health or safety.
- **Lawsuits and legal actions:** We may share information about you in response to a court or administrative order, or in response to a subpoena.
- **Organ and tissue donation:** We can share information about you with organ procurement organizations.
- **Medical examiner or funeral director:** We can share information with a coroner, medical examiner, or funeral director when an individual dies.
- **Workers' compensation, correctional institutions and other government requests:** We can share information with employers for workers' compensation claims. We also share information with correctional institutions about their inmates. Information may also be shared with health oversight agencies when authorized by law, and other special government functions such as military, national security and presidential protective services.
- **Research:** We can use or share your information for certain research projects that have been evaluated and approved through a process that considers a member's need for privacy.

We may contact you in the following situations:

- **Treatment options:** To provide information about treatment alternatives or other health related benefits, providers or services that may be relevant to your care.
- **Fundraising:** We may contact you about fundraising activities, but you can tell us not to contact you again.

YOUR RIGHTS THAT APPLY TO YOUR HEALTH INFORMATION

When it comes to your health information, you have certain rights.

- **Get a copy of your health and claims records:** You can ask to see or get a paper or electronic copy of your health and claims records and other health information we have about you. We will provide a copy or summary to you usually within thirty (30) calendar days of your request. We may charge a reasonable, cost-based fee. Access may be denied in some circumstances or when a certain law prohibits your access. In some circumstances you may have this decision reviewed.

- **Ask us to correct your health and claims records:** You can ask us to correct health information that you think is incorrect or incomplete. We may deny your request, but we'll tell you why in writing. These requests should be submitted in writing to the contact listed below.
- **Request confidential communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Reasonable requests will be approved. We must say "yes" if the disclosure of your information could endanger you.
- **Ask us to limit what we use or share:** You can ask us to restrict how we share your health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- **Get a list of those with whom we've shared information:** You can ask for a list (accounting) of the times we've shared your health information for six (6) years prior, who we've shared it with, and why. We will include all disclosures except for those about your treatment, payment, and our health care operations, and certain other disclosures (such as those you asked us to make). We will provide one (1) accounting a year for free, but we will charge a reasonable cost-based fee if you ask for another within twelve (12) months.
- **Get a copy of this privacy notice:** You can ask for a paper copy of this Notice at any time, even if you have agreed to receive it electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you**: If you have a designated health care agent or medical power of attorney, or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- **File a complaint if you feel your rights are violated:** You can complain to the U.S. Department of Health and Human Services Office for Civil Rights if you feel we have violated your rights. We can provide you with their address. You can also file a complaint with us by using the contact information below. We will not retaliate against you for filing a complaint.

Contact Information:

Sanford Health Plan
Customer Service
PO Box 91110
Sioux Falls, SD 57109-1110
(800) 752-5863 (toll-free) | TTY/TDD 711

Security Health Plan
Customer Service
1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000
(800) 472-2363 (toll-free) | TTY/TDD 711

OUR RESPONSIBILITIES REGARDING YOUR HEALTH INFORMATION

- We are required by law to maintain the privacy and security of your health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your health information.
- We must follow the duties and privacy practices described in this Notice and offer to give you a copy.
- We will not use, share, or sell your information for marketing or any purpose other than as described in this Notice unless you tell us to in writing. You may change your mind at any time

by letting us know in writing.

CONFIDENTIALITY OF SUBSTANCE USE DISORDER RECORDS

Specialized substance use disorder treatment at certain facilities is protected by federal law 42 CFR Part 2 (a "Part 2 Program"). Member records at a Part 2 Program, testimony about those records, or the fact an individual has been treated at a Part 2 Program may not be disclosed unless:

1. The member consents in writing;
2. The disclosure is allowed by a court order or required by other state or federal law;
3. The disclosure is needed for treatment in a medical emergency; or
4. The disclosure is related to a crime committed at a Part 2 Program, or required for suspected child abuse or neglect reporting.

You may agree to provide a general consent allowing the disclosure of Part 2 Program records for treatment, payment, and health care operations. You may also choose to revoke a previous general consent subject to certain limitations.

CALLING, TEXTING, AND EMAILING

We may contact you about your plan and health care using the phone numbers and email addresses that you provide to us. This may include using an automated phone dialing system, pre-recorded or synthetic voice messages, texting, or email. When we contact you in this manner, you will be given the opportunity to opt out of receiving similar communications going forward.

Because texts and emails are not encrypted, there is a risk that someone else could read or access these messages. We therefore take steps to limit the amount of health information that they contain. You may choose to opt out of these messages at any time.

NOTICE OF AFFILIATED COVERED ENTITY DESIGNATION

Sanford Health Plan, Security Health Plan, Sanford Health, Marshfield Clinic Health System, and The Evangelical Lutheran Good Samaritan Society, as covered entities under common ownership and control, have designated themselves and subsidiaries as a single covered entity for purposes of the Health Insurance Portability and Accountability Act (HIPAA). Sanford Health Plan and Security Health Plan share health information about members with the affiliated covered entity participants for treatment and other purposes as allowed by HIPAA and applicable law.

NOTICE OF SHARED RECORD

As affiliated covered entities, the participants may share records to support information sharing and operations as allowed by HIPAA and applicable law.

NOTICE OF ORGANIZED HEALTH CARE (OHCA) ARRANGEMENT

Sanford Health Plan, Security Health Plan, Sanford Health, Marshfield Clinic Health System, and The Evangelical Lutheran Good Samaritan Society participate in an Organized Health Care Arrangement (OHCA)

under the Health Insurance Portability and Accountability Act (HIPAA). This OHCA allows the participating entities to share information about members and patients to promote the joint operations allowed under HIPAA related to treatment, payment, and health care operations.

CHANGES TO THIS NOTICE

We may change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request and online at www.sanfordhealthplan.com and www.securityhealth.org.

EFFECTIVE DATE

This Notice of Privacy Practices is effective February 15, 2026.

SECTION XI – DEFINITIONS

Actively employed – A member is considered to be actively employed when he or she is performing job duties on a regular, full-time basis. This may include paid vacation or other authorized leave and any regular nonworking holiday.

Adverse benefit determination – An adverse benefit determination is any of the following:

- A denial, reduction of, termination of or failure to provide or pay (in whole or in part) for a benefit based on a determination of a member's eligibility to participate in a plan. This includes results from the application of any utilization review.
- A failure to cover an item or service for which benefits are otherwise provided because Security Health Plan determines it to be:
    - Experimental
    - Investigational
    - Not medically necessary.
- Any rescission, including any cancellation or discontinuance of coverage that has a retroactive effect.

Affordable Care Act – Also known as the Patient Protection and Affordable Care Act and health care reform. A law established in 2010. This law targets medical consumer protections, new health coverage options, improved patient care and lower medical costs.

Allowable expense – A necessary, reasonable and customary item of expense for health care.

Allowed amount – The lesser of the amount billed or the negotiated rate provided in the contract between Security Health Plan and the in-network provider.

Amendment – Any attached written description of additional or alternative provisions to the policy. Amendments are subject to all conditions, limitations and exclusions of the policy.

Ancillary charge – 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 as defined in Schedule of Benefits.

Audiologist – A health care professional who evaluates, diagnoses, treats and manages hearing loss and balance disorders in adults and children.

Autism spectrum disorders – A general term for a group of complex disorders of brain development. The disorders are characterized, in varying degrees, by difficulties in social interaction, verbal and nonverbal communication, and repetitive behaviors. Examples of autism spectrum disorders include:

- **Autistic disorder** – Characterized by significant language delays, social and communication challenges, and unusual behaviors and interests. Many people with autistic disorder also have intellectual disability.
- **Asperger syndrome** – Characterized by milder symptoms of autistic disorder. People with Asperger syndrome might have social challenges and unusual behaviors and interests. However, they typically do not have problems with language or intellectual disability.
- **Pervasive developmental disorder** – Not otherwise specified (PDD-NOS; also called "atypical autism") – People who meet some of the criteria for autistic disorder or Asperger syndrome, but not all, may be diagnosed with PDD-NOS; people with PDD-NOS usually have fewer and milder symptoms than those with autistic disorder; the symptoms might cause only social and communication challenges.

Balance billing – When a provider bills you for the difference between the provider's charge and Security Health Plan's reimbursement amount.

Benefit year – The 12-month period as defined in a member's Schedule of Benefits.

Calendar year – January 1 through December 31.

Certificate of Coverage/Certificate – The document issued to a subscriber under the policy that outlines coverage and guides coverage decisions.

Certified nurse midwife (CNM) – CNMs are registered nurses who have graduated from a midwifery education program accredited by the American College of Nurse Midwives (ACNM) Division of Accreditation, and have passed a national certification exam administered by the American Midwifery Certification Board (AMCB). Many CNMs have received their midwifery education as part of a master's degree program. Most CNM's work in hospitals.

Certified professional midwife (CPM) – CPMs are graduates of accredited midwifery programs or demonstrate they have met all NARM (North American Registry of Midwives) certification requirements through equivalency, called the Portfolio Evaluation Process. CPMs have also passed the NARM (National Certification Examination) and must renew their certification every three years.

Child/children – The term child includes the subscriber's:

- Natural child
- Stepchild
- Legally adopted child
- A child placed with a family for adoption
- A child whom legal guardianship has been awarded to the subscriber or subscriber's spouse
- The child of a dependent child younger than 18 (grandchild).

The term child includes a full-time student 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 younger than 27 when attending, on a full-time basis, an institution of higher learning.

Claim – A request for payment submitted to Security Health Plan for reimbursement of health care services received. It is a document that outlines the services received, including the diagnosis, treatment and costs involved.

Claimant – A member who requests a benefit or benefits in accordance with Security Health Plan's claim processing procedures as found in Section VIII.

Clinical trial – A registered and approved scientifically controlled study of the safety and effectiveness of a therapeutic agent (as a drug or vaccine) using consenting human subjects.

Coinsurance – A member's share of the costs of a covered health care service, calculated as a percent of the allowed amount for the service.

Community support program (CSP) – A coordinated care and treatment program which provides a range of treatment, rehabilitation and support services. These are provided for persons with chronic mental illness through an identified treatment program and staff to ensure:

- Ongoing therapeutic involvement
- Individualized treatment
- Rehabilitation

- Support services.

Confinement – The period starting with admission on an inpatient basis (more than 24 hours) to a hospital or other licensed health care facility for treatment of an illness or injury. Confinement ends when discharge from the same hospital or facility occurs. Transfer to another hospital or facility for continued treatment of the same or related illness or injury is considered one confinement.

Copay/copayment – A specified dollar amount a member is required to pay to the provider each time certain covered health care services are provided.

Cosmetic services – Services and procedures to improve the patient's self-esteem, personal well-being, or to indirectly treat psychiatric or emotional problems or disorders. This includes procedures done solely to improve appearance. This also includes services and procedures provided in connection with or resulting from complications of cosmetic services or procedures.

Cost sharing – A member's portion of health care costs not covered by Security Health Plan; examples include copays, deductibles and coinsurance.

Crisis intervention – Immediate evaluation and mental health care to persons experiencing a mental health crisis. Services are available 24 hours a day, 7 days a week, within the county's:

- Mental health outpatient programs.
- Mental health inpatient program.
- Mental health day treatment program.

The program is staffed by mental health professionals, paraprofessionals or by trained mental health volunteers backed up by mental health professionals.

Custodial care – Services given to a member if:

- The member does not require the technical skills of a registered nurse.
- The member needs assistance for activities of daily living including, but not limited to:
    - Dressing
    - Bathing
    - Eating
    - Walking
    - Taking prescription drugs
    - Maintaining continence.
- The services are not likely to improve the member's physical and/or mental condition; no further functional improvement is expected.

Services may be considered custodial, as determined by Security Health Plan, even if a member is under the care of a physician, and the physician prescribes services to support and maintain the member's physical and/or mental condition.

Day treatment services or partial hospitalization program – A medically directed intensive, or intermediate short-term mental health and substance abuse treatment, for a period of less than 24 hours but more than 4 hours in a day in a licensed or certified facility or program. It is a monitored, non-residential treatment service. This consists of regularly scheduled sessions of various modalities, such as individual and group counseling and case management, provided under the supervision of a physician to treat.

Deductible – The amount a member is required to pay in a benefit year before benefits are payable by Security Health Plan under the policy. Member can refer to their Schedule of Benefits for their annual deductible.

Dependent – A person who relies on someone else for health care coverage. Dependents include a subscriber's spouse and/or child.

Dependent wrap – Out-of-area dependent coverage is also sometimes referred to as dependent wrap. This offers your enrolled dependents access to care outside of the service area as long as the subscriber resides in the service area. They will be able to receive covered services from out-of-network providers at the in-network benefit level. The dependents will need to have a physical address outside of the subscriber's address service area. UCR may apply.

Dietitian – A certified expert on diet and nutrition.

Directed donor program – A blood-donation program that allows patients to recruit their own donors to meet blood needs for planned surgeries or transfusions.

Durable medical equipment – Medical equipment that is:

- Appropriate for use in the member's home.
- Prescribed by a physician.
- Medically necessary for a specific illness or injury.
- Able to withstand repeated use.
- Not disposable.
- Not implantable within the body.

Emergency – An emergency is defined as a medical condition involving acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

- Serious jeopardy to the member's health, or with respect to a pregnant member, serious jeopardy to the health of the member or the unborn child
- Serious impairment to the member's bodily functions
- Serious dysfunction of one or more of the member's body organs or parts

Such conditions, for example, include heart attack, stroke, poisoning, loss of consciousness or loss of breathing.

Enrollment period – The period in which an eligible employee or individual may apply for coverage.

ERISA – The Employee Retirement Income Security Act of 1974.

Expedited grievance – Any dissatisfaction with the administration, claims practices or services of Security Health Plan involving a situation where the normal duration of the grievance process could have adverse health effects for the member.

Experimental and/or investigational – The use of any treatment, procedure, facility, equipment, drug, object, device or supply for a member's illness or injury that Security Health Plan determines:

- Is not demonstrated to be as beneficial as established alternatives.
- Has not been approved:
    - By the appropriate governmental agency, such as but not limited to the U.S. Food and Drug Administration.
    - For the purpose it is being used for, which includes the member's medical condition.
- Does not have enough scientific evidence to draw conclusions about the effect of the service on your health.

- Based on a review of current peer-reviewed medical literature in the United States, it fails to demonstrate, at a minimum, an equivalent clinical outcome when compared to standard and/or conventional treatment for the condition.
- The treatment requires a written investigational or research protocol and is a treatment protocol based upon, or similar to those used in, ongoing clinical trials.



Note: A treatment, procedure, supply, device or drug may be considered experimental and/or investigational even if:

- **The provider has performed, prescribed, recommended, ordered or approved it.**
- **It is the only available procedure or treatment for the condition.**

Family coverage – Coverage applies to a covered subscriber and eligible spouse and/or eligible dependent children. To be covered, a dependent must be properly enrolled and approved by Security Health Plan for coverage.

Follow-up care – Follow-up care refers to services you receive once your condition has stabilized after needing emergency care. Follow-up care is covered only when received from in-network providers. If you require follow-up care before you can return to the service area, you must obtain prior authorization from Security Health Plan.

Follow-up care rules are different for students who attend school out of the service area. Students can receive up to 120 days of follow-up care from out-of-network health providers after emergency care. Please call Security Health Plan's Customer Service Department to assure that student follow-up care claims are properly processed.

Formulary – A list of covered prescription drugs, products or devices that have been approved by the U.S. Food and Drug Administration (FDA). The formulary is developed and reviewed by a committee of physicians and pharmacists. It is subject to periodic review and changes. The formulary is available upon request or at www.securityhealth.org/prescription-tools.

Full-time student and full-time student status – A covered dependent child enrolled full-time at an accredited

- Secondary school.
- Vocational school.
- Technical school.
- Adult education school.
- College.
- Or university.

Such school must provide a schedule of scholastic courses and its principal activity must be to provide an academic education. An apprenticeship program is not considered an accredited school, college or university for this purpose.

Grievance – Any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an insured including any of the following:

- Provision of services.
- Determination to reform or rescind a policy.
- Determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders.
- Claims practices.

Also see expedited grievance.

Group policy – The agreement between Security Health Plan and the employer to provide health care benefits to its employees. Security Health Plan agrees to insure members of the employer for future health care services covered through benefit payments and subject to the terms, conditions and provisions of coverage.

Habilitative/habilitation services – Health care services that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities.

Hearing aids – Electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Health maintenance organization (HMO) – A health insurance plan that provides medical coverage within a network of participating providers.

Home care services – Health care services directly provided to a member in the member's home under a written home care plan submitted by the member's attending physician.

Hospice care – Specific health care services provided to a member whose life expectancy, as certified by a physician, is six months or less, and that provides services through a licensed hospice care provider. The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided to ease pain and make the member as comfortable as possible.

Hospital – An institution accredited by the Joint Commission, which provides 24-hour nursing services and a professional staff of licensed physicians and surgeons providing and supervising services. Its chief function must be to provide diagnostic, therapeutic, surgical and treatment facilities for individuals suffering from illness or disease, whether physical or mental.

Illness – A physical sickness, condition or disease including mental health and substance abuse.

Immediate family – A covered member's:

- Spouse
- Natural and adopted children
- Children placed with them for adoption
- Stepchildren
- Parents
- Grandparents
- Grandchildren
- Brothers and sisters, and spouses of such people.

Implantable hearing device – Any implantable instrument or device that is designed to enhance hearing.

Infertility – The physical inability to conceive after at least 12 consecutive months of unprotected sexual intercourse. This inability must be documented by a provider. Infertility is not considered to be an illness.

Injury/injuries – Bodily damage caused by an incident. The bodily damage must result from the incident directly and independently of all other causes. Tooth damage caused by chewing is not considered an injury.

In-network provider – A health care provider or facility who has a provider contract with Security Health Plan to provide medical treatment, services or supplies for Security Health Plan members. This includes:

- Physicians
- Practitioners
- Qualified treatment facilities
- Pharmacies
- Hospitals
- Behavioral health care hospitals and clinics.

In-network pharmacy – A pharmacy that has a contract with Security Health Plan or its delegate to provide prescription drugs to Security Health Plan members. Long-term care pharmacies are typically excluded.

Inpatient rehabilitation facility – A hospital that provides rehabilitation health services on an inpatient basis, as authorized by law. This could be a special unit of a hospital that is designated as such a facility. These services include:

- Physical therapy
- Occupational therapy
- Speech therapy.

Intensive outpatient programs – Treatment for mental illness and/or psychoactive substance use disorders provided in accordance with the Placement Criteria of the American Society of Addiction Medicine. Programs that have the capacity for planned, structured, service provision of at least two hours per day and three days per week. The range of services offered could include group, individual, family or multi-family group psychotherapy, psychoeducational services and medical monitoring.

Intensive services – Evidence-based behavioral therapy that is designed to help an individual with autism spectrum disorder overcome cognitive, social and behavioral deficits associated with the disorder. Intensive level services may include evidence-based speech therapy and occupational therapy provided by a qualified therapist when such therapy is based on, or related to, an individual's therapeutic goals and skills, and is associated with evidence-based behavioral therapy.

Licensed mental health professional – A clinical social worker, a marriage and family therapist or a professional counselor who is licensed according to state statute.

Licensed midwife – A midwife who holds a license but may or may not have attained the CPM credential is called a licensed or registered midwife.

Licensed skilled nursing facility – A nursing facility licensed as a skilled nursing facility by the state in which it is located. The facility must be staffed, maintained and equipped to provide the following skilled nursing services continuously:

- Observation and assessment.
- Skilled care.
- Restorative programs.
- Activity programs.

These services must be provided under professional direction and medical supervision as needed.

Maintenance care – A treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life and is performed to maintain condition or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance.

Maternity services – The prenatal, delivery and postnatal care that is billed by the provider under the obstetrical package. Additional prenatal visits for high-risk pregnancy from the obstetrical provider are also considered maternity care.

Medicaid – Benefits available under state plans pursuant to Title XIX of the Social Security Act of 1965, as amended.

Medical benefit drug – An eligible drug that has been approved by the U.S. Food and Drug Administration (FDA) and is predominantly administered by a provider in the:

- Provider's office
- Clinic
- Hospital
- Or by home infusion.

These drugs are primarily administered by:

- Intravenous (IV) injection
- IV infusion
- Intramuscular (IM) injection
- Intravitreal (ocular) injection
- Intra-articular (joints) injection
- Intrathecal injections
- Limited subcutaneous injections required in an emergency for acute conditions
- Drugs required as part of a surgical or diagnostic procedure.

Medical necessity – Medically necessary care involves treatments, services or supplies provided by a hospital or provider that are required to identify or treat a member's illness or injury. These must be determined by Security Health Plan medical directors to be:

- Consistent with the member's illness or injury.
- In accordance with generally accepted standards of medical practice that are based on valid scientific evidence to show the expected health benefits published in peer-reviewed medical literature.
- Not solely for the convenience of a member, hospital or other provider.
- The most appropriate level of service that can be safely provided to the member in the most cost-effective manner.
- The service is performed in the least costly setting that is medically appropriate.

Security Health Plan reserves the right to review all claims to determine whether services are medically necessary. Security Health Plan may use the services of physician consultants, peer-review committees of professional societies or hospitals and other consultants to make this decision. A service is not always deemed medically necessary when a provider has prescribed, ordered, recommended or approved a treatment, service or supply, or has informed a member of its availability.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are medically necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

Medical services – Service provided to a member in the treatment of illness or injury.

Medical supplies – Items which are:

- Used primarily to treat an illness or injury.
- Generally not useful to a person in the absence of an illness or injury.
- Prescribed by a physician.

Medicare – Benefits available under Title XVIII of the Social Security Act of 1965, as amended.

Member – A covered person or dependent enrolled for coverage in Security Health Plan.

Mental health conditions – Also called nervous or mental disorders, as listed in the latest edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) or the International Classification of Diseases. This includes substance abuse, alcoholism or drug abuse.

Non-intensive services – Evidence-based therapy that occurs after the completion of treatment for intensive services and that is designed to sustain and maximize gains made during treatment with intensive level services or, for an individual who has not and will not receive intensive level services, evidence-based therapy that will improve the individual's condition.

Orthotics – Devices that provide support for damaged joints, tendons, muscles or bones, and that may be customized to a patient's functional deficits and anatomy.

Out-of-network provider – A provider who does not have a contract with Security Health Plan.

Outpatient treatment facility – A medical facility licensed or approved by the Department of Health Services to provide mental health care services. These outpatient services must meet the Department of Health Services' standards.

Parent – Mother, father or legal guardian.

Physical illness – A change in a function, structure or system of the human body that causes, or will cause if left undetected or untreated, a deterioration of the healthy state or the function, structure or system of the human body. For purposes of this Certificate, physical illness includes pregnancy and complications of pregnancy.

Physician – A person who received a degree in medicine from an accredited college or university is a doctor or surgeon licensed by the state in which he/she is located and provides health care services while acting within the lawful scope of his/her license.

Plan – A health insurance plan includes a package of covered health care items and services and sets how much it will pay for those items and services. In other words, a health plan will describe the types of health care items and services it will cover (help pay for) and how much it will pay for those items and services.

Policy – The entire agreement issued to the employer that includes all of the following (if applicable):

- Group Insurance Policy
- Certificate
- Schedule of Benefits
- Riders
- Amendments
- Application

- Any supplemental applications

Policyholder – The business that owns the insurance policy.

Prescription drug – A drug, product or device that has been approved by the U.S. Food and Drug Administration (FDA) and that must, under federal or state law, be dispensed only pursuant to a prescription order. A prescription drug includes a drug that because of its characteristics is appropriate for self-administration or administration by a non-skilled caregiver. This includes investigational prescription drugs used to treat human immunodeficiency virus (HIV) as described in the state statute 632.895(9), as well as other drugs designated by Security Health Plan.

Prescription order – The lawful request made by a physician or other provider who is authorized to prescribe drugs.

Preventive services – Preventive care to detect and prevent future illnesses. These services are identified based on the U.S. Preventive Services Task Force, the Affordable Care Act and internal guidelines. Preventive service recommendations are based on evidence-based guidelines that services for a population of individuals based on age, gender and other factors. These recommendations apply only to people who have no signs, symptoms or diagnosis of the specific disease or condition under evaluation.

Primary care provider – A health care provider a member sees to coordinate their health care. This includes:
- Physicians.
- Nurse practitioners.
- Physician's assistants.

These providers include adolescent medicine, family practice, internal medicine, general practice or pediatrics.

Primary plan/secondary plan – The subsection titled "Order of benefit determination rules" describes when this plan is a primary plan or secondary plan in comparison with another plan covering the person. When there are more than two plans covering the person, this plan may be a primary plan as to one or more plans and may be a secondary plan as to a different plan or plans.

Prior authorization request – A process to determine whether Security Health Plan will provide coverage before the member gets the drugs, services or equipment for:
- Prescription drugs.
- Medical benefit drugs.
- Medical/surgical services.
- Behavioral health services.
- Inpatient services.
- Equipment.

Private-duty nursing – Nursing care that is provided to a member on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:
- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a home health agency on a per-visit basis for a specific purpose.
- The service is provided to a member by an independent nurse who is hired directly by the member or his/her family; this includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Professional services – Services provided by licensed medical professionals directly to a member to treat a member's illness or injury.

Prosthetic – An item that replaces all or part of a limb or an internal body organ.

Provider – A doctor, doctor of philosophy (PhD), hospital, clinic and any other person, institute or entity licensed, certified or otherwise authorized to provide health care services within the scope of their license as defined in Wisconsin statute s.146.81(1).

Qualifying event – A qualifying event is a life event as defined in the Health Insurance Portability and Accountability Act (HIPAA) that would allow you to enroll or make changes to your existing coverage. Examples of qualifying events include a change in marital status, birth of a child, or beginning employment.

Reconstructive procedures – Procedures performed to improve function of abnormal structures of the body caused by:

- Congenital defect.
- Developmental abnormalities.
- Trauma.
- Infection.
- Tumors.
- Disease.

Rehabilitative/rehabilitation services – Health care services in a variety of inpatient or outpatient settings. These services help you get back or improve skills and functioning for daily living that have been lost or impaired because you were sick or hurt. These services may include:

- Physical and occupational therapy
- Speech-language therapy
- Psychiatric rehabilitation.

Resident legal alien – A foreign-born United States resident who is not a U.S. citizen. A resident legal alien is also known as a permanent resident or a lawful permanent resident. Individuals on a work Visa are eligible for coverage which extends to their children (who we do not require documentation of).

Residential treatment facility – A facility that provides a program of effective substance-abuse or mental illness services and meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a physician.
- It has or maintains a written, specific and detailed treatment program, requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in 24-hour-a-day, structured surroundings:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.

A residential treatment facility that qualifies as a hospital is considered a hospital.

Residential treatment services – A facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of participants diagnosed with alcohol, drug or substance abuse disorders or mental illness. The program is a clinically supervised, peer-supported,

therapeutic environment with clinical involvement. The service provides substance abuse treatment in the form of:

- Counseling.
- Immediate access to peer support through the environment.
- Intensive case management.

This may include direct education and monitoring in the areas of:

- Personal health and hygiene.
- Community socialization.
- Job readiness.
- Problem resolution counseling.
- Housekeeping.
- Financial planning.

Schedule of Benefits – The document accompanying this Certificate that describes specific benefits and benefit limitations for covered expenses provided under the terms of this Certificate. Your Schedule of Benefits outlines your plan's deductible, coinsurance and copay amounts associated with different medical or pharmacy services.

Service area – The geographic area where Security Health Plan is licensed to sell insurance.

Services – Hospital, professional, surgical, maternity, medical or any other service provided by a provider. Services include prescription drugs, treatment and supplies.

Skilled nursing care – Services that are furnished on a physician's order and must be delivered by licensed personnel, such as a registered nurse, including therapies.

Sound natural teeth – Teeth that are not diseased or affected by periodontal disease. A sound tooth is one sufficiently supported by its natural structure (bone and gum tissue) and one that is formed by the human body and is not decayed or weakened by previous dental work at the injury site.

Specialty prescription drugs – An eligible drug designated as specialty by Security Health Plan.

Subscriber – A subscriber is the individual who holds the policy, the "policyholder". That typically is a parent or adult member in a family.

Substance-abuse services – Treatment for alcoholism and substance-use disorders.

Supportive care – The care for a member having reached maximum therapeutic benefit, in whom periodic trials of therapeutic withdrawal fail to sustain previous therapeutic gains that would otherwise progressively deteriorate.

Telehealth – A virtual visit between a patient and a provider that can be done via secure videoconferencing.

Treatment – Care provided by a physician or other licensed provider for the diagnosis, remedy and therapy of an illness or injury.

Urgent care – Health care services that are required to prevent serious deterioration of your health as a result of an unforeseen sickness, injury or the onset of sudden or severe symptoms.

Usual, customary and reasonable (UCR) – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

Weight loss interventions – Services or programs for weight reduction, dietetic control, appetite suppression or other popular weight control programs such as Weight Watchers®.

SecurityHealth Plan®

Promises kept, plain and simple.

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