INDIVIDUAL
& FAMILY PLAN

Individual Policy



2026

SecurityHealth Plan℠

Promises kept, plain and simple.®

Policy document

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 Policy is a general description of the health insurance benefits provided to Security Health Plan members and their qualified dependents.

This document and a member's Schedule of Benefits make up the member's policy. Together, they contain information members need to know about what Security Health Plan covers and what it doesn't cover. Read this Policy and the Schedule of Benefits to understand the coverage and avoid unexpected costs. Members may contact Security Health Plan with questions.



IMPORTANT NOTICE: Benefits are not available when services are received from an out-of-network provider except in limited circumstances. Please go to www.securityhealth.org/directory, call Customer Service at 1-844-293-9624, TTY 711, or email Customer Service at shpcsweb@securityhealth.org to verify whether a provider is a network provider. Our office hours are 7 a.m. to 5:30 p.m., Monday through Friday.

Every effort has been made to ensure that the information contained in this Policy is accurate. Any benefit described is subject to the terms and conditions of the coverage. Please refer to the Schedule of Benefits included in new member materials to verify coverage, obligations and responsibilities under the coverage.

The policy is guaranteed renewable except as stated in the policy's termination provisions. See "When the Coverage Ends."



YOUR RIGHT TO RETURN THIS POLICY. Please read this policy right away. If you are not satisfied with it for any reason, you may return it to Security Health Plan within 10 days after delivery. Upon return, the policy is no longer valid. If you return the policy within the 10 days, Security Health Plan will refund all premiums to the person who paid it.

Benefits listed in this Policy are only available as long as the coverage remains in force. The Policy and Schedule of Benefits should be read together to ensure accurate information. We include definitions of terms stated throughout this document in Section XI, titled "Definitions."

SECURITY HEALTH PLAN OF WISCONSIN, INC.
1515 NORTH SAINT JOSEPH AVENUE
P.O. BOX 8000
MARSHFIELD, WI 54449-8000
Customer Service phone: 1-844-293-9624 · 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.

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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. Generally, a member must use a provider within Security Health Plan's network unless otherwise specified in his or her Schedule of Benefits. Our most current Provider Directory can be found 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.



IMPORTANT NOTICE: For the HMO and EPO plans, benefits are available only when services are received from a network provider except in limited circumstances. Please go to www.securityhealth.org/directory, contact Security Health Plan's Customer Service Department at 1-844-293-9624, TTY 711 or shpcsweb@securityhealth.org to verify whether a provider is a network provider. Our office hours are 7 a.m. to 5:30 p.m., Monday through Friday.



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 deductibles, coinsurance and copayments. Fees that go over the UCR fee schedule do 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.

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. 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.

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 1-844-293-9624 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 1-844-293-9624.

SECTION II – HOW TO JOIN OUR PLAN

Joining our plan

You may have joined Security Health Plan directly or used the American Health Benefits Exchange, also called the Health Insurance Marketplace or Federally-facilitated Exchange (FFE), and hereafter called "the Marketplace." If you have purchased this plan directly from Security Health Plan and have further questions about your eligibility, contact Security Health Plan. If you have purchased your coverage through the Marketplace, contact the Marketplace at 1-800-318-2596, or www.healthcare.gov.

Who is eligible for coverage

No one can be denied coverage because of a medical condition. If you enroll through the Marketplace, the Marketplace will determine whether you are eligible to join our plan. Generally, to qualify for enrollment with Security Health Plan, an individual must:

- Be a citizen of the United States or a resident legal alien, or living in the United States with a valid work Visa
- Reside within our service area

People eligible for Security Health Plan coverage include:

- Subscriber – A subscriber is the individual who holds the policy, the "policyholder". That typically is a parent or adult member in a family.
- Child subscriber – The minor person under a policy that does not cover any adults from a family.
- Dependents – A person who relies on someone else for health care coverage. Dependents include a subscriber's spouse and/or child.
- Child – The subscriber's legal ward, natural child, adopted child, stepchild or a child placed for adoption with the 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.

Continuation of coverage for students

In the case of a non-active-duty child, if the child's physician certifies the medical necessity of the leave of absence and documentation supporting such necessity is submitted to Security Health Plan, coverage may be continued for a period of time.

A dependent child who has coverage because the child is a full-time student that was called to federal active duty in the National Guard or a reserve component of the U.S. armed forces while the child was under 27 years of age when attending, on a full-time basis, at an institution of higher learning and who would otherwise lose coverage because he or she is no longer a full-time student may be entitled to continued coverage for a period of time.

When to enroll and when coverage begins



Be sure to report any significant life changes to Security Health Plan if you enrolled directly through Security Health Plan. If you do not report changes that affect your eligibility for coverage, your coverage could be retroactively terminated and you could be responsible for any claims costs after the date your coverage ended.

People who are eligible for coverage may enroll with Security Health Plan or the Marketplace during the annual enrollment period or special enrollment periods for a qualifying event. Documentation to validate an adoption and/or a loss of coverage qualifying event is always required. Documentation for other qualifying events may also be required. Examples of qualifying events are:

- You or your dependent lose coverage under another health plan (except where the loss is due to a failure to pay premiums or a cancellation or rescission)
- You gain a dependent through marriage, birth, adoption, placement for adoption, placement in foster care or legal guardianship
- You become eligible for coverage due to a permanent move
- The Marketplace determines that you or your dependent becomes eligible to enroll in or change health plan

You have 60 days from the date of the qualifying event to enroll with Security Health Plan. In general, if you notify Security Health Plan or the Marketplace (where applicable) between the first and 15th day of any month, then your coverage will be effective as of the first day of the following month, and if you notify Security Health Plan or the Marketplace (where applicable) between the 16th and last day of any month, then your coverage will be effective as of the first day of the second following month.

If you know that you will be losing coverage under another health plan in advance, you can notify Security Health Plan or the Marketplace (where applicable) up to 60 days prior to and 60 days after the date you lose coverage, and your coverage will be effective on the first day of the month following the date you lose coverage.

In the case of marriage, or in the case where you or your dependent loses coverage under another health plan, coverage is effective on the first day of the following month after you notify Security Health Plan or the Marketplace (where applicable).

In the case of birth, adoption, placement for adoption, or placement in foster care or legal guardianship, coverage is effective on the date of birth, adoption, placement for adoption, or placement in foster care or legal guardianship unless you elect a coverage effective date of the first day of the month following the qualifying event.

Coverage of a newborn

A newborn child is covered from the moment of that child's birth and for the next 60 days. In order to continue coverage for the newborn child after the 60-day period, you must notify

Security Health Plan or the Marketplace (where applicable) of the child's birth and pay the required premium for that child's coverage during that 60-day period. If you fail to notify Security Health Plan or the Marketplace (where applicable), then 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

- Security Health Plan can terminate coverage for members who do not pay their premiums.
- Members newly enrolling in coverage must effectuate their policy, or their coverage will be voided/cancelled.
- Members who receive tax credits through the Marketplace have a three-month grace period in which to make a payment. If Security Health Plan does not receive a payment, the coverage will end as of the end of the first month of grace.
- Members who do not receive tax credits through the Marketplace have a 10-day grace period in which to make a payment. If Security Health Plan does not receive a payment, the coverage will end as of the last date of paid coverage.
- If coverage is terminated or voided, the member is responsible for any claims costs incurred by Security Health Plan on the member's behalf after coverage ends.
- The date of death of the covered subscriber, spouse, dependent or other covered member. All deaths for policies through the Federally-facilitated Exchange must be reported to the Marketplace for updates.
- Security Health Plan can end a member's coverage if the member performs an act, practice or omission that constitutes fraud, or if the member makes an intentional misrepresentation of material fact. For example, if the member allows someone who is not covered to make a claim, then that would be an act that constitutes fraud. If Security Health Plan ends a member's coverage due to fraud or intentional misrepresentation of material fact, then Security Health Plan can require the member to pay back the benefits.
- To the extent permitted by law, Security Health Plan can end a member's coverage if the member moves outside its service area.
- 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.

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 1-844-293-9624.

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 1-800-548-1224. Provider assistance can help direct those requests that go to an outside vendor for prior authorization review.

- Prime Therapeutics Management – Medical benefit drugs
- Northwood – Durable medical equipment (DME)
- eviCore – High end imaging (CT, MRI, PET), cardiac imaging and catheterizations, sleep study, pain management, musculoskeletal services (surgery and therapy services), and radiation therapy

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.

What is the process to request an "exception" for a prescription drug?

- Sometimes our members need access to drugs that are not listed on the plan's formulary (drug list). These medications are reviewed through the formulary exception review process. The member or provider can submit the request to us by faxing the Pharmacy Formulary Exception Request form.
- Members or prescribing providers can contact us to request a coverage determination or formulary exception.

    - A statement from the prescribing provider supporting the request is required.
    - If "Urgent" or "Fast," please indicate in the written or verbal request.
- To initiate an exception process, send an email request to shppharmacyum@securityhealth.org. The request should include:
    - Member's name.
    - Provider's name, address and telephone number.
    - Prescription drug strength, dosage form and directions.
    - Diagnosis.
    - Lab medical data.
    - The medical reason for the request.
- For an "Urgent" or "Fast" request, an approval or denial will be granted no later than 24 hours.
- For a "Standard" request, the decision shall be granted or denied no later than 72 hours.
- Security Health Plan will only approve a request for an exception if an alternative prescription drug included on the plan's formulary, a lower-tiered prescription drug or additional utilization restrictions would not be as effective in treating the condition and/or would cause the member to have adverse medical effects.
- Notification of the coverage decision or exception request will be provided to the requesting provider by fax, the member by mail, and the pharmacy by telephone or fax if the pharmacy information is included with the request.
- If your request is denied, the member will not have coverage for the prescription drug under the member's prescription drug benefit. The member may purchase the prescription drug without drug coverage, or the member can discuss with the provider appropriate prescription drugs that are covered under the member's prescription drug benefit.

If the member feels we have denied the non-formulary request incorrectly, the member may ask us to submit the case for an external review by an impartial, third-party reviewer known as an independent review organization (IRO). We must follow the IRO's decision. An IRO review may be requested by a member, member's representative or prescribing provider by mailing, calling or faxing the request to one of the partner review entities.

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 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 Policy, 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 Policy, 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. 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 in a member's Schedule of Benefits. A 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.

A service is not always deemed medically necessary or guaranteed to be covered when a physician 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 Policy
- 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 1-800-548-1224.

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.

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

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 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
- 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 Policy.
- 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

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

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.

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 prescription drugs or other high-cost medications may be limited to a one-month supply.
- 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 prescriptions should be submitted electronically using your Security Health Plan pharmacy card. For prescriptions not submitted electronically, any dollar amounts in excess of the electronic contracted charge for that drug will not be covered.
- Members receiving multiple opioid-based prescriptions from several different prescribers and pharmacies may be required to use only one pharmacy for future prescriptions.
- 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.
- Drugs replaced for lost, stolen, broken or destroyed drugs are limited to one early refill per drug per plan year.
- 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:

- 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

Limitations

Habilitative and rehabilitative therapy services require prior authorization for the services performed, not for location of service.

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

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

- Habilitative and rehabilitative therapy services require prior authorization when done outpatient.
- Services performed during an inpatient or observation stay do not require prior authorization.
- See your Schedule of Benefits for limits on the number of visits for habilitative and rehabilitative therapy.

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 until the end of the month the member turns 19, including:
    - Dilation/refraction.
    - Contact lens fitting.
- Vision services which are reasonable and necessary to evaluate signs and symptoms of a disease or to diagnose or treat an illness or injury

Examples of covered eyewear include:
- Glasses
    - For enrolled dependents, until the end of the month the dependent turns 19, one pair of glasses per year. This includes lenses and frames. This is limited to a selection of glasses approved by Security Health Plan. Contact Security Health Plan for more information.
    - Single-vision lenses.
    - Conventional (lined) bifocals or trifocals.
    - Lenticular lenses.
    - Ultraviolet protective coatings
    - Polycarbonate lenses
    - Blended-segment lenses
    - Standard or premium progressive lenses
    - Intermediate vision lenses
    - Photochromic lenses (glass or plastic)
    - Polarized lenses
    - Standard or premium anti-reflective coatings
    - Ultra anti-reflective coatings
    - Hi-index lenses

- Contact lenses
    - For enrolled dependents, until the end of the month the dependent turns 19, one pair every calendar year in lieu of eyeglasses.
- Also covered
    - Standard intraocular lens after cataract surgery
    - First standard external lens (contacts or glasses) after cataract surgery

Not covered

- Preventive eye exams for adults 19 and older.
- Dilation/refraction for adults 19 and older.
- Eyewear for adults 19 and older.
- 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 Policy.
- 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 Policy 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 Policy or Schedule of Benefits; services resulting or arising from complications of, or incidental to, any service not covered under the Policy 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 Policy.
- 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).
- 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 used for cosmetic purposes, including hair growth.
- Drugs used for fertility treatment purposes.
- 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.
- Raw or bulk chemicals.
- Prepackaged, 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.
- 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 Policy 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.

SECTION VII – HOW OUR COVERAGE WORKS WHEN MEMBERS HAVE MEDICARE

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.

SECTION VIII – HEALTH PLAN BUSINESS GUIDELINES

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 insured 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 Policy, 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 Policy, 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 1-844-293-9624 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 other documentation or information to support the grievance.
Mail/deliver to:
Attn: Grievances
Security Health Plan of Wisconsin, Inc.
1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000.

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 1-800-472-2363 (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 participation in the administration of the plan, including enrollment and benefit determinations, you can file a grievance with a Compliance & Privacy Specialist at:

Security Health Plan
Attn: Grievances
1515 North Saint Joseph Avenue
Marshfield, WI 54449-8000
Phone: 715-221-9596 (TTY: 711)
Fax: 715-221-9424
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 Compliance & Privacy Specialist 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
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-844-293-9624 (TTY 711).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-293-9624(TTY 711).

Hmoob (Hmong)
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-293-9624 (TTY 711).

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-293-9624 (TTY 711)。

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-293-9624 (TTY 711).

العربية (Arabic)
مقرب لصتا .ناجملاب كل رفاوتت ةيوغللا ةدعاسملا تامدخ نإف ،ةغللا ركذا ثدحتت تنك اذإ :ةظوحلم
(رقم هاتف الصم 4269-392-448-1)
والبكم: 117.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-293-9624 (телетайп 711).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-293-9624 (TTY 711) 번으로 전화해 주십시오.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-293-9624 (TTY 711).

Deitsch (Pennsylvania Dutch)
Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: 1-844-293-9624 (TTY 711).

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍ ລິການຊ່ ວຍເຫ ຼືອ ດ້ ານພາສາ, ໂດຍບ ໍ ເສ ັ ງ ຄ ່ າ, ແມ ່ ນມ ໍ ່ ອມໃຫ ້ ທ ່ ານ. ໂທຣ 1-844-293-9624 (TTY 711).

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-293-9624 (ATS 711).

Polski (Polish)
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-293-9624 (TTY 711).

ह िंदी (Hindi)
ध्यं न दं : यदद आप ह िंदी बोलतं हं तो आपकं दलए मं फ्त मं भं षं सह यत सं वं एं उपलब्ध हं । 1-844-293-9624 (TTY 711) पर कॉल करें ।

Shqip (Albanian)
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-844-293-9624 (TTY 711).

Tagalog (Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-293-9624 (TTY 711).

Oroomiffa (Oromo/Somalia)
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-293-9624 (TTY 711).

Large print – If you require materials in large print, please call 1-844-293-9624 (TTY 711).

SECTION X – HOW SECURITY HEALTH PLAN PROTECTS YOUR PRIVACY

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice is effective June 16, 2022.

Who we are

This Notice describes the privacy practices of Security Health Plan of Wisconsin, Inc. ("we", "our" or "us"). Security Health Plan of Wisconsin, Inc., Marshfield Clinic Health System, Inc., MCHS Hospitals, Inc., Family Health Center of Marshfield, Inc., Lakeview Medical Center, Inc., of Rice Lake, Memorial Hospital, Inc., of Neillsville, Wisconsin, Beaver Dam Community Hospitals, Inc., and Dickinson County Healthcare System are legally separate entities. Together, these legally separate entities have formed an Organized Health Care Arrangement, or "OHCA," which allows them to manage care in an efficient and patient-friendly manner. We provide health benefits to you under the terms of a health insurance policy or under other health benefit programs such as BadgerCare Plus/Medicaid or a Medicare Advantage plan. Federal law requires us to provide this Notice to you.

Security Administrative Services, LLC is a wholly-owned subsidiary of Security Health Plan and is hereby included in this Notice of Privacy Practices.

Our privacy obligations

Your privacy is important to us and we take very seriously the confidentiality of medical records and other personal information. Security Health Plan employees protect access to personal health information in any form (oral, written and electronic) and maintain the confidentiality of such information. In addition, we are required by federal and state law to protect the privacy of health information and to provide you with this Notice of our legal duties and privacy practices. When we use or disclose your health information, we are required to follow the practices described in this Notice (or other notice in effect at the time of the use or disclosure).

We must follow either federal or state law, whichever is more protective of your privacy rights or provides you with greater rights of access to or amendment of your health information. For example, if federal law allows certain disclosures of your health information without your written authorization but state law requires your written authorization, we must follow state law.

We may change the privacy practices described in this Notice at any time. Changes would apply to all health information we maintain at the time of the change. If we make a material change to this Notice, we will send the new Notice to you (or information about the material change and how to obtain the revised Notice) in our next annual mailing if you are then covered by us. In addition, we will post any new notice on our website at www.securityhealth.org/privacy. You also may obtain any new notice by contacting us as described at the end of this Notice.

How we may use and disclose your information

In certain situations described in the section below entitled Limits on Our Use or Disclosure of Your Information, we must obtain your written authorization to use and/or disclose your health information. However, we do not need such authorization to use and disclose your health information for the following purposes:

Payment. We may use and disclose your health information to obtain payment of premiums for your coverage and to determine and fulfill our responsibility to provide your health plan benefits – for example, to make coverage determinations such as whether a service is experimental, to

administer claims, and to coordinate benefits with other coverage you may have. We may also disclose your health information to another health plan or a health care provider for its payment activities – for example, for the other health plan to determine your eligibility.

Treatment. We may disclose your health information to your health care provider for the provider's treatment of you. Treatment is the provision, coordination, or management of your health care and related services – for example, evaluating treatment options.

Health care operations. We may use and disclose your health information for our health care operations – for example, to provide customer service, to conduct quality assessment and improvement activities, or credentialing activities. We also may disclose your health information to another health plan or a health care provider that has or had a relationship with you so that it can conduct certain health care operations activities – for example, for the other health plan to perform case management. We may use your health information to train our staff and students.

Plan sponsors. We may disclose to group health plan sponsors certain health information to the extent reasonably necessary for specific plan administration purposes.

Marketing communications. We may use and disclose your health information for marketing purposes only with your authorization, except that no authorization is required to provide you with marketing materials in a face-to-face encounter or to provide a promotional gift of nominal value.

Sale of health information. We may sell your health information only with your authorization.

Health-related benefits. We may contact you to give you information about certain health-related benefits and services that may be of interest to you and that are included within your plan benefits. We may also contact you to recommend alternative treatments, health care providers, or care settings.

Public health activities. If required or allowed by law, we may disclose your health information to public health authorities to:

- Prevent or control disease, injury, or disability.
- Report child abuse or neglect.
- Report abuse of elderly individuals or adults at risk.
- Report problems with products and reactions to medications.
- Report disease or infection exposure.

Health oversight activities. We may disclose your health information to an insurance regulatory authority and other government agencies legally responsible for oversight of the health care system or ensuring compliance with the rules of government benefit programs. This disclosure may include health information related to beneficiary eligibility or other regulatory programs, such as civil right laws.

Judicial and administrative proceedings. We may disclose your health information in a judicial or administrative proceeding in response to a legal order or other lawful process.

Law enforcement officials. We may disclose your health information to the police or other law enforcement officials as required or allowed by law, to comply with an appropriate administrative or court order, or to protect us against fraud or other illegal activity.

To avert a serious threat to health or safety. We may disclose your health information to prevent or lessen a serious and imminent threat to the health or safety of an individual or the general public.

Specialized government functions. We may disclose your health information to units of the government with special functions, such as the U.S. military or the U.S. Department of State.

Workers' Compensation. We may disclose your health information as necessary to comply with Workers' Compensation or similar laws.

Coroners, medical examiners and funeral directors. We may release health information to a coroner, medical examiner, or funeral director as permitted by law to carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of law enforcement, we may disclose information for certain purposes. For example, we may disclose information necessary to provide you with health care.

Research. There are situations when researchers and research staff may use or disclose your health information for research purposes without your authorization. Researchers may conduct research that simply involves reviewing your health information and that of others with similar conditions or diseases. In such situations, researchers will not contact you for your authorization, but must obtain permission from the Institutional Review Board that is set up to protect the welfare and privacy of research participants as required by law. Researchers may also review your health information to see if there are enough persons with a specific disease or condition to conduct a study or to see if you would be a good candidate for a study.

Business associates. We may disclose your health information to persons or organizations that perform a service for us or on our behalf that requires the use or disclosure of health information. Such persons or organizations are our business associates. For example, we may disclose your health information to the pharmacy benefits management company that processes our prescription drug claims.

To comply with the law. We may disclose your health information when required by any other law not already referred to in this Notice.

Individuals involved in your care or payment for your care. In certain limited situations, we may disclose health information to people such as your family members, relatives, or close friends that you identify as being involved in your care or payment for your care. The information disclosed would be limited to information we believe is directly relevant to their involvement and only to the extent we determine it would be in your best interest. In most circumstances, you must be given a chance to object to such a disclosure. We may disclose applicable health information to family members and others who were involved in a decedent's care or payment for care prior to the member's death, unless doing so is contrary to the decedent's prior expressed preference made known to us. Limited health information may also be disclosed to organizations involved in disaster relief efforts.

Limits on our use or disclosure of your information

Disclosures with an authorization. We may use or disclose your health information for purposes other than those described above only when you give us your permission on the Security Health Plan authorization form. This means we may not be able to share certain information with your spouse, parent or child without an authorization signed by you. To give us permission to disclose your health information to a family member, agent or other person, contact Security Health Plan Customer Service at 1-844-293-9624, TTY 711 or email Customer Service at

shpcsweb@securityhealth.org to request a HIPAA Authorization to Use and Disclose Protected Health Information form. You may revoke an authorization unless we have relied on it or the state law gives us the right to contest a claim or the policy itself and the authorization was obtained as a condition of obtaining insurance coverage. The revocation must be in writing and sent to us.

Uses and disclosures of your highly confidential information. State laws require special privacy protections for certain highly confidential information about you. This highly confidential information may include a subset of your health information:

1. Maintained in psychotherapy notes
2. About mental illness or developmental disabilities
3. About alcohol and drug abuse prevention, treatment and referral
4. About HIV/AIDS testing
5. About reproductive health, or
6. About child abuse and neglect.

These laws may restrict our uses and disclosures beyond the general limitations described in this Notice. Except for certain purposes described in this Notice, we will generally obtain your written authorization for uses or disclosures of highly confidential information. The only exception to this is if we are allowed by law to disclose your highly confidential information for certain purposes without your written authorization. In addition, we may not use genetic information for underwriting purposes.

Federal laws have restrictive requirements for health information regarding treatment of substance use disorders. In order for us to disclose your substance use disorder health information for a purpose other than those permitted by law, we must have your authorization. The only exception to disclosure of such information, without your authorization, is in limited circumstances as regulated by federal law. For instance, in the case of your medical emergency, we may disclose your member identifying information without your prior consent.

Your individual rights

Right to request additional restrictions. You may ask for restrictions on uses and disclosures of your health information: (1) for treatment, payment and health care operations; (2) to family or friends involved in your care or payment for care; or (3) for disaster relief efforts. While we will consider all requests for additional restrictions, we are not required to agree to your request. To ask for a restriction, you must obtain a HIPAA Authorization to Use and Disclose Protected Health Information form from Security Health Plan Customer Service and submit the completed form to our Privacy Office. We will send you a written response.

Right to request confidential communications. We will accommodate a reasonable request to receive communications of your health information from us by alternative means of communication or at alternative locations if the request clearly states that disclosure of that information could endanger you. For example, you may request that we send materials to a P.O. Box instead of a street address. To make a request, you must obtain a Request for Confidential Communications form from Security Health Plan Customer Service and submit the completed form to us.

Right to inspect and copy your health information. You may have access to our records that contain your health information and are used to make decisions about your benefits. Under limited circumstances, we may deny you access to a portion of your records, such as mental health records or information gathered for a judicial proceeding. To request access, you must obtain an Access Request for Protected Health Information form from Security Health Plan Customer Service and submit the completed form to our Privacy Office. There may be charges, such as copying and mailing costs, and costs of preparing an explanation or summary, if

applicable. You should note that, if you are a parent or legal guardian of a minor (child under age 18), certain portions of the minor's health information may not be accessible to you (for example, records related to substance abuse treatment, HIV test results, or if the minor is emancipated).

Right to request amendment of your records. You have the right to request that we amend your health information maintained in our records. To request amendment, you must obtain a Request for Amendment of Health Information form from Security Health Plan Customer Service and submit the completed form to our Privacy Office. All requests for amendment must be in writing. We may deny your request if certain circumstances apply. If your physician or other health care provider created the information that you desire to amend, you should contact the provider to amend the information.

Right to accounting of disclosures. You may ask for a list of certain disclosures of your health information made by us, if any. This list will not include disclosures made to you, for treatment, payment, and health care operations, or for certain other purposes. To request such a list, you must obtain an Accounting Request for Disclosures of Individually Identifiable Health Information form from Security Health Plan Customer Service and submit the completed form to our Privacy Office. Your request must state a time period that may not be longer than the six years preceding your request. If you request a list more than once during any 12 month period, we will charge you a reasonable fee for the additional requests.

Right to notification of a breach. We will notify you if there is a breach of your health information. We will notify you within 60 days of our discovery of the incident if we breach your unsecured protected health information.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

Right to a paper copy of this notice. You may ask for a paper copy of this notice, even if you previously agreed to receive it electronically. You may also access this notice on our website at www.securityhealth.org.

Complaints. If you are concerned that we have violated your privacy rights, you may contact our Privacy Hotline by calling our toll-free number shown below. You may also file written complaints with the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint.

Questions. If you have any questions or would like additional information about your rights or the information in this Notice, you may contact Customer Service as shown below.

Security Health Plan
1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000
1-866-339-0289 (TTY 711) – Privacy Hotline
1-844-293-9624 (TTY 711) – Customer Service Center
Fax: 715-221-9500
shpcsweb@securityhealth.org

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.

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.

Child subscriber – Designated subscriber under a policy that does not cover any adults.

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.

Claim determination period – A calendar year. However, it does not include any part of a year during which a person has no coverage under this plan.

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.

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.

Federally-facilitated Exchange – Also called the Health Insurance Marketplace or "Marketplace." The marketplace established by the federal government under the Affordable Care Act (health care reform) for individuals who want to buy health insurance 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.

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 Policy, 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 individual or family that includes all of the following (if applicable):

- This document
- Schedule of Benefits
- Riders
- Amendments
- The member's application
- Any supplemental applications

Policyholder – The person who carries 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.

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 Policy that describes specific benefits and benefit limitations for covered expenses provided under the terms of this Policy. 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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