



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, refer to [www.securityhealth.org/certificates](http://www.securityhealth.org/certificates) or 1-800-472-2363. For general definitions of common terms, such as [allowed amount](#), [balance-billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-800-472-2363 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$6,950 individual / \$13,900 family	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$8,550 individual / \$17,100 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.securityhealth.org/directory">www.securityhealth.org/directory</a> or call 1-800-472-2363 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance-billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



- All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations & Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's office</a> or clinic</b>	Primary care visit to treat an injury or illness	30% coinsurance	Not covered	None
	<a href="#">Specialist</a> visit	30% coinsurance	Not covered	Please refer to your policy <a href="#">plan</a> documents for more specific information.
	<a href="#">Preventive care/screening</a> /immunization	Covered at 100%	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% coinsurance	Not covered	Please refer to your policy <a href="#">plan</a> documents for more specific information.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.securityhealth.org/prescription-tools">www.securityhealth.org/prescription-tools</a>	Generic drugs (Tier 1)	\$25 copayment	Not covered	<a href="#">Provider</a> means pharmacy for purposes of this section. Most pharmacies nationwide are included in the <a href="#">provider network</a> (more than 50,000 pharmacies). You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have prior authorization requirements. You may be required to use a lower-cost drug(s) prior to coverage being available for certain prescribed drugs.
	Preferred brand drugs (Tier 2)	\$60 copayment	Not covered	
	Non-preferred brand drugs (Tier 3)	\$120 copayment	Not covered	
	<a href="#">Specialty drugs</a> (Tier 4)	40% coinsurance	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	None
	Physician/surgeon fees	30% coinsurance	Not covered	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.securityhealth.org](http://www.securityhealth.org)

Common Medical Event	Services You May Need	What You Will Pay		Limitations & Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% coinsurance	30% coinsurance	<a href="#">Cost sharing</a> may apply for services performed in the ER (such as labs, X-rays).
	<a href="#">Emergency medical transportation</a>	30% coinsurance	30% coinsurance	None
	<a href="#">Urgent care</a>	30% coinsurance	30% coinsurance	When you're in the service area, benefits are payable for urgent care services only when provided by an affiliated <a href="#">provider</a> . <a href="#">Cost sharing</a> may apply for services performed in the UC (such as labs, X-rays).
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	None
	Physician/surgeon fee	30% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	Not covered	Please refer to your policy <a href="#">plan</a> documents for more specific information.
	Inpatient services	30% coinsurance	Not covered	
If you are pregnant	Office visits	30% coinsurance	Not covered	None
	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% coinsurance	Not covered	Limited to 60 visits per individual per calendar year.
	<a href="#">Rehabilitation services</a>	30% coinsurance	Not covered	PT/OT/ST - 20 visits per therapy type per individual per calendar year.
	<a href="#">Habilitation services</a>	30% coinsurance	Not covered	PT/OT/ST - 20 visits per therapy type per individual per calendar year.
	<a href="#">Skilled nursing care</a>	30% coinsurance	Not covered	Limited to 30 days per individual per confinement.
	<a href="#">Durable medical equipment</a>	30% coinsurance	Not covered	Please refer to your policy <a href="#">plan</a> documents for more specific information.
	<a href="#">Hospice services</a>	30% coinsurance	Not covered	None

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Common Medical Event	Services You May Need	What You Will Pay		Limitations & Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If your child needs dental or eye care</b>	Children's eye exam	Covered at 100%	Not covered	No charge first visit, cost-share each visit following.
	Children's glasses	30% coinsurance	Not covered	Glasses are generally not covered; please refer to your <a href="#">plan</a> documents for specifics.
	Children's dental check-up	Not covered	Not covered	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 or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)	• Dental care	• Private-duty nursing
• Acupuncture (if prescribed by a physician for rehabilitation purposes)	• Infertility treatment	• Routine eye care (Adult)
• Bariatric surgery	• Long-term care	• Routine foot care
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)	
• Chiropractic care	• Hearing aids

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.securityhealth.org](http://www.securityhealth.org)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is your state insurance department, of the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeal Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact Security Health Plan at 1-715-221-9258 or 1-844-293-9624. You may also contact the Office of the Commission of Insurance (OCI) at (608) 266-3585 or (800) 236-8517.

**Does this plan provide Minimum Essential Coverage?** Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverages. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standard?** Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next page.* —————

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the plan. Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,950
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

#### This EXAMPLE event includes services like:

[Specialist](#) office visits (prenatal care)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (ultrasounds and blood work)  
[Specialist](#) visit (anesthesia)

<b>Total Example Cost</b>	<b>\$12,700</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$6,950
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,600
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$8,550</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,950
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

#### This EXAMPLE event includes services like:

[Primary care physician](#) office visits (including disease education)  
[Diagnostic tests](#) (blood work)  
[Prescription drugs](#)  
[Durable medical equipment](#) (glucose meter)

<b>Total Example Cost</b>	<b>\$5,600</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$6,600
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$6,600</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,950
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

#### This EXAMPLE event includes services like:

[Emergency room care](#) (including medical supplies)  
[Diagnostic tests](#) (x-ray)  
[Durable medical equipment](#) (crutches)  
[Rehabilitation services](#) (physical therapy)

<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,900
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## Addendum

### Notice of Nondiscrimination:

#### Discrimination is against the law

Security Health Plan of Wisconsin, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Security Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

#### 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. 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, age, disability or sex, you can file a grievance with:

#### 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](mailto: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, Security Health Plan can 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 or 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Language Access Services:

### English:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-472-2363 (TTY: 711).

### Spanish:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-472-2363 (TTY: 711).

### Hmong:

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-472-2363 (TTY: 711).

### 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 1-800-472-2363 (TTY: 711)。

### German:

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-472-2363 (TTY: 711).

### Russian:

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-472-2363 (телетайп: 711).

### Vietnamese:

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-472-2363 (TTY: 711).

### Pennsylvania Dutch:

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-472-2363 (TTY: 711).

### French:

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-472-2363 (ATS : 711).

### Polish:

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-472-2363 (TTY: 711).

### Hindi:

ध्यान दः यद आप हदी बोलते ह तो आपके लिए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-800-472-2363 (TTY: 711) पर कॉल कर।

### Albanian:

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-472-2363 (TTY: 711).



Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-472-2363 (TTY: 711).

Italian:

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-472-2363 (TTY: 711).

Portugues:

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-472-2363 (TTY: 711).

French Creole:

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-472-2363 (TTY: 711).

Oroomiffa (Oromo/Somalia):

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-472-2363 (TTY: 711).

