Schedule of Benefits - Open Access

Group 608052 - ALTOONA SCHOOL DISTRICT
Benefit Year: August 1st through June 30th
Effective Date: 08/01/2015

SecurityHealth Plan®
www.securityhealth.org

Security Health Plan certifies that you and any covered dependents have coverage as described in your Certificate and Schedule of Benefits. The effective date is shown on the letter you received with your identification cards. Coverage is subject to the terms, conditions, exclusions, limitations and all other provisions of the group policy.

This Schedule shows how much you pay for certain types of services. It shows additional benefits, limitations or exclusions not shown in your Certificate. It also provides a very general summary of your benefits for certain types of services. **You will need to read it along with your Certificate for details about your coverage.** Benefits are based on the benefit year shown above.

Reimbursement is limited for out-of-network benefits to the reasonable and customary charges for cost-effective services. It is also subject to applicable deductible, coinsurance and copayment amounts. If a charge exceeds our reasonable and customary fee limit, we may reimburse less than the billed charge. In this case, the member is responsible for any amount charged in excess of such fees. The member is also responsible for applicable deductible, coinsurance and copayment amounts.

Network Tier 1 ~ Security Health Plan primary network
Network Tier 2 ~ All other licensed providers in Wisconsin counties of Barron, Chippewa, Dunn, Eau Claire and Trempealeau
Network Tier 3 ~ All other out-of-area and out-of-network licensed providers

Your Responsibilities	Tier 1 - In-Network	Tier 2 - Out-of-Network	Tier 3 - Out-of-Network
Deductible	$3,000 per individual $6,000 per family	$3,000 per individual $6,000 per family	$6,000 per individual $12,000 per family
Coinsurance	20% of the next $5,000 per individual $10,000 per family	20% of the next $5,000 per individual $10,000 per family	40% of the next $5,000 per individual $10,000 per family
Office visit copayment	$25 copayment per office visit (Copayment does not apply to preventive exams)	$25 copayment per office visit (Copayment does not apply to preventive exams)	Subject to deductible and coinsurance
Emergency room facility copayment (Waived if admitted to the hospital as an inpatient)	$100 copayment per visit Balance of charge after copayment applies to annual deductible and coinsurance. Copayments continue after deductible and coinsurance have been satisfied.	$100 copayment per visit Balance of charge after copayment applies to annual deductible and coinsurance. Copayments continue after deductible and coinsurance have been satisfied.	$100 copayment per visit Balance of charge after copayment applies to annual deductible and coinsurance. Copayments continue after deductible and coinsurance have been satisfied.

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Your Responsibilities	Tier 1 - In-Network	Tier 2 - Out-of-Network	Tier 3 - Out-of-Network
Annual out of pocket (Deductible, coinsurance & copayments) In-network amounts accumulate to the out-of-network, out-of-pocket maximum. Out-of-network amounts accumulate to the in-network, out-of-pocket maximum.	$4,000 per individual $8,000 per family	$4,000 per individual $8,000 per family	$8,000 per individual $16,000 per family
Student coverage follow up care In addition to the benefits described in the Follow-up Care section of the Certificate, students living outside of the service area for the purpose of attending school (other than secondary school), are provided benefits for covered services from non-affiliated providers.	Such coverage shall be provided at the in network level of benefits.	Such coverage shall be provided at the in network level of benefits.	Such coverage shall be provided at the in network level of benefits.

Your Benefits	Tier 1 - In-Network	Tier 2 - Out-of-Network	Tier 3 - Out-of-Network
Ambulance services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Anesthesia services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Chiropractic services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Durable medical equipment and medical supplies (Including insulin pump and supplies)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hearing examinations	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Home health care	Subject to deductible and coinsurance (Limited to 40 visits per individual per calendar year)	Subject to deductible and coinsurance (Limited to 40 visits per individual per calendar year)	Subject to deductible and coinsurance (Limited to 40 visits per individual per calendar year)

Your Benefits	Tier 1 - In-Network	Tier 2 - Out-of-Network	Tier 3 - Out-of-Network
Hospice care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hospital emergency room services			
• **Emergency room facility** (Copayment waived if admitted to hospital as inpatient)	$100 copayment per visit Balance of charge after copayment applies to annual deductible and coinsurance. Copayments continue after deductible and coinsurance have been satisfied.	$100 copayment per visit Balance of charge after copayment applies to annual deductible and coinsurance. Copayments continue after deductible and coinsurance have been satisfied.	$100 copayment per visit Balance of charge after copayment applies to annual deductible and coinsurance. Copayments continue after deductible and coinsurance have been satisfied.
• **Other emergency room services**	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hospital inpatient services (Including semi-private or special care room, operating room, ancillary services and supplies)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hospital outpatient and surgical center services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Maternity services			
• **Hospital services**	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Physician services**	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	Tier 1 - In-Network	Tier 2 - Out-of-Network	Tier 3 - Out-of-Network
Mental health services			
• **Inpatient care**	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Outpatient care**	6 days covered at 100% per calendar year then subject to deductible and coinsurance	6 days covered at 100% per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Transitional care**	6 days covered at 100% per calendar year then subject to deductible and coinsurance	6 days covered at 100% per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
Office visits	$25 copayment per office visit (Copayment does not apply to preventive exams)	$25 copayment per office visit (Copayment does not apply to preventive exams)	Subject to deductible and coinsurance
Outpatient laboratory services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Outpatient radiology services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Outpatient therapy services			
• **Occupational therapy**	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Physical therapy**	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Speech therapy**	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	Tier 1 - In-Network	Tier 2 - Out-of-Network	Tier 3 - Out-of-Network
Physician services			
• **Hospital services**	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Other services in an office**	Subject to deductible and coinsurance (Preventive immunizations covered at 100%)	Subject to deductible and coinsurance (Preventive immunizations covered at 100%)	Subject to deductible and coinsurance

Your Benefits	Tier 1 - In-Network	Tier 2 - Out-of-Network	Tier 3 - Out-of-Network
Preventive benefit			
• **Comprehensive physical examination** (complete physical) ~ Well-baby care ~ Well-child care ~ Adolescent well-care ~ Adult well-care	Covered at 100%	Covered at 100%	Subject to deductible and coinsurance
• **Gynecological examination for women** (breast exam and pelvic exam)	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Digital prostate examination for men**	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Preventive hearing test**	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Comprehensive preventive vision examination**	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Mammogram to screen for breast cancer**	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Pap smear to screen for cervical cancer**	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Colonoscopy screening for colorectal cancer**	1 every two years then subject to deductible and coinsurance	1 every two years then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Other screenings for colorectal cancer** ~ Sigmoidoscopy ~ Double contrast barium enema ~ Fecal occult blood testing	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	Tier 1 - In-Network	Tier 2 - Out-of-Network	Tier 3 - Out-of-Network
• **Screening laboratory services** Including, but are not limited to: basic metabolic panel, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), prostate specific antigen (PSA), and urinalysis.	Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance	Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Bone mineral density (dexa scan) to screen for osteoporosis in women**	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Chlamydia screening for women**	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Ultrasound for screen of an abdominal aortic aneurysm for men**	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Immunizations and vaccinations** (including those needed for travel)	Covered at 100%	Covered at 100%	Subject to deductible and coinsurance
Skilled nursing facility	Subject to deductible and coinsurance (Limited to 30 days per individual per confinement)	Subject to deductible and coinsurance (Limited to 30 days per individual per confinement)	Subject to deductible and coinsurance (Limited to 30 days per individual per confinement)
Substance abuse services			
• **Inpatient care**	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Outpatient care**	6 days covered at 100% per calendar year then subject to deductible and coinsurance	6 days covered at 100% per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Transitional care**	15 days covered at 100% per calendar year then subject to deductible and coinsurance	15 days covered at 100% per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	Tier 1 - In-Network	Tier 2 - Out-of-Network	Tier 3 - Out-of-Network
Surgical services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Temporomandibular joint disorders or TMJ non-surgical treatment	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Transplant services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Not covered
Vision examinations	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance

Pharmacy	
• Up to 30 days worth of medication constitutes a 1-month supply. For most maintenance medications you may receive up to a 90-day supply and if applicable, 3 copayments and/or coinsurance and/or deductible will be assessed. • Pharmacy mail service may supply maintenance medications in a 90-day supply and if applicable, 2 copayments and/or coinsurance and/or deductible will be assessed. • Copayments and/or coinsurance and/or deductible will be assessed on oral anti-diabetic medications. • 100% coverage for tier 1 and tier 2 insulin and diabetic testing supplies. (Not subject to deductible, if applicable.) • Insulin and diabetic testing supplies not listed on tier 1 or tier 2 of the Formulary Guide will require medical exception review from the Security Health Plan Pharmacy Services Department. (This does not include insulin pumps and related supplies. Please refer to the durable medical equipment section of the Schedule of Benefits for coverage.) • 100% coverage for smoking cessation products, limited to 180 days per calendar year, as indicated in the Formulary Guide. • Limited coverage for sexual dysfunction medications (e.g. Viagra®), as indicated in the Formulary Guide. • Over-the-counter (OTC) medications are generally excluded; however, coverage may be provided for selected OTC medications with a prescription authorization, as indicated in the Formulary Guide. • The use of a specialty pharmacy may be required for select medications, as indicated in the Formulary Guide.	$10 copayment per tier 1 prescription or refill. $25 copayment per tier 2 prescription or refill. $50 copayment per tier 3 prescription or refill. Deductible, copayments and coinsurance may apply to the max out of pocket amounts.

Dependent Coverage
Dependent children are covered from birth through the end of the month they attain the age of 26. In addition, a child who meets the criteria above and is a full-time student as defined in the Certificate has an extension past age 26 IF the child was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was under 27 years of age and attending, on a full-time basis, an institution of higher learning. Such extension ends on the date described in the full-time student definition in the Certificate.