Individual Policy

Classic (HMO)
Select (EPO)
POLICY DOCUMENT

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. Read this Policy and the Schedule of Benefits to understand the coverage and avoid unexpected costs. Members may contact Security Health Plan Customer Service at 1-800-472-2363 or shpcs@securityhealth.org with questions.

IMPORTANT NOTICE: Benefits are not available when services are received from a non-network health care provider except in limited circumstances. Please go to www.securityhealth.org/directory, call Customer Service at 1-800-472-2363, or email Customer Service at shpcs@securityhealth.org to verify whether a health care provider is a network health care 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.

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. The words in this document printed in italics are defined in the Definitions section at the end of this Policy.

SECURITY HEALTH PLAN OF WISCONSIN, INC.
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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 network health care providers 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 Customer Service at 1-800-472-2363 or shpcs@securityhealth.org.

How to receive services from non-network health care providers

Non-network health care providers do not have a contract with Security Health Plan, and generally are not covered by Security Health Plan. However, benefits may be payable for services by a non-network health care provider if Security Health Plan determines that the covered service is not available from any network health care provider. 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 a non-network health care 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 network health care provider
- The services are a covered benefit under the member’s coverage
- The services are medically necessary and appropriate

When a member receives prior authorization for a service from a non-network health care 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, and the location for services. Any additional services recommended by and received from a non-network health care provider are not covered unless prior authorization is given.

Remember: A recommendation or referral by a network health care provider to see a non-network health care provider is not covered unless prior authorized by Security Health Plan or otherwise stated in a member’s Schedule of Benefits. Please have your health care provider contact Security Health Plan before you receive non-emergency or non-urgent services from non-network health care providers.

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, 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 Customer Service at 1-800-472-2363 or shpcs@securityhealth.org. If you have purchased your coverage through the Marketplace, contact the Marketplace at 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
• Reside within our service area

People eligible for Security Health Plan coverage include:

• **Subscriber** – A subscriber is the individual who carries the policy. That typically is a parent or the oldest enrolled member in a family.

• **Child subscriber** – The youngest person under a policy that does not cover any adults from a family

• **Dependents** – A dependent is usually the subscriber’s spouse or domestic partner and children. Eligible children must be younger than 26 or such other age as shown in the insured’s Schedule of Benefits

A child is eligible for coverage through an insured when the child is:

• The subscriber’s legal ward, natural child, adopted child, stepchild or a child placed for adoption with the insured.
• Not on active duty with the military including the National Guard or reserves
• A natural child of a dependent child (as described above) until the dependent child is 18

**WHEN TO ENROLL AND WHEN COVERAGE BEGINS**

People who are eligible for coverage may enroll with Security Health Plan during annual enrollment periods or special enrollment periods for a qualifying event. Examples of qualifying events are:

• Changes in marital status
• Birth, adoption or legal guardianship of a child
• Moving into or out of the service area

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.

**WHEN COVERAGE ENDS**

• **Security Health Plan** can terminate coverage for members who do not pay their premiums. Members who receive tax credits through the Marketplace have a 90-day grace period in which to make a payment. If Security Health Plan does not receive a member’s payment, the member’s coverage will end as of the month following the last date of paid coverage. If this happens, the member is responsible for any claims costs incurred by Security Health Plan on the member’s behalf after coverage ends.

• **Security Health Plan** can end a member’s coverage for fraud, misrepresentation or false information if the member allows someone who is not covered to make a claim. If a member commits fraud to obtain coverage, Security Health Plan can require the member to pay back the benefits that have been paid on the member’s behalf.

• To the extent permitted by law, **Security Health Plan** can end a member’s coverage if the member moves outside its service area.

**SECTION III – MEMBER BENEFITS**

Security Health Plan will provide coverage for medically necessary services for members while their coverage is in force. Benefits are payable only for covered services that are received from a network health care provider, except as specifically noted otherwise in this Policy or in a member’s Schedule.
of Benefits. Network health care providers are listed in the Provider Directory (www.securityhealth.org/directory). Even if a network health care provider has referred a member to another health care provider, benefits will only be payable for that health care provider’s services if that health care provider is a network health care provider or payment is authorized under this Policy, or a member’s Schedule of Benefits.

Members may call Customer Service at 1-800-472-2363 before they receive a service to determine whether Security Health Plan will provide coverage.

Members generally must use network health care providers unless otherwise specified in a member’s Schedule of Benefits. Non-emergency and non-urgent services from a non-network health care 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 health care provider must provide Security Health Plan with a written referral, and Security Health Plan must approve the referral before the services are provided.

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 a network health care provider
- Received from a non-network health care provider, but only with prior authorization
- Received from a non-network health care provider in an emergency or urgent care
- Listed as a covered expense under this Policy
- Consistent with the member’s Schedule of Benefits
- Medically necessary

Health care providers should contact Security Health Plan to determine whether a prior authorization is required for any service listed.

AMBULANCE SERVICES AND NON-AMBULANCE TRANSPORT

Covered
- Licensed professional ambulance services for emergency medical care and transportation to the nearest hospital where appropriate medical care is available
- Licensed professional ambulance services that provide transportation to a hospital that offers care not available at the original hospital

Not covered
- Ambulance transport to a home or outpatient setting
- Medical van transportation
- Non-emergency licensed professional ambulance services unless authorized by Security Health Plan
- First responders and rescue services
- Transportation from an acute facility to a sub-acute setting

ANESTHESIA SERVICES

Covered
Anesthesia services related to surgical, maternity or other services for illnesses or injury.

AUTISM SPECTRUM DISORDERS

Prior authorization is required from Security Health Plan for services related to autism spectrum disorders, which include autism disorder, Asperger’s syndrome and pervasive developmental disorder not otherwise specified. Ask your health care provider to request prior authorization from Security Health Plan before you receive services related to autism spectrum disorders.

Covered
Security Health Plan covers intensive services and non-intensive services as described.
INTENSIVE SERVICES
Benefits for intensive services may begin when an enrolled child is between 2 and 9 years old. Intensive services target cognitive, social and behavioral improvements through evidence-based therapy. Most services will be provided for an enrolled child who has an autism spectrum disorder when a parent or legal guardian is participating in the therapy. The prescribed therapy must:

- Be based on a treatment plan developed by a qualified health care provider, who is a state-licensed psychiatrist, psychologist or social worker, or a certified psychotherapist. Treatment plans must require that the enrolled child be present and engaged in the intervention. The plan will include at least six months and 20 hours a week of evidence-based behavioral intensive therapy, treatment and services with specific cognitive, social, communicative, self-care or behavioral goals that are clearly defined, directly observed and continually measured, while addressing the characteristics of autism spectrum disorders.
- Be implemented by qualified health care providers, qualified supervising health care providers, qualified professionals, qualified therapists or qualified paraprofessionals. Qualified professionals are individuals who work under the supervision of an outpatient mental health clinic and a licensed treatment professional. Qualified therapists are state-licensed speech-language pathologists or occupational therapists. Qualified paraprofessionals are trained assistants to qualified supervising health care providers, health care providers and therapists.
- Be provided in an environment conducive to achieving the goals of the enrolled child’s treatment plan.
- Include training and consultation, and professional team meetings for implementing therapeutic goals.
- Include a qualified health care provider directly observing the enrolled child at least once every two months.

Intensive services will be covered for up to four years. Security Health Plan may count previous intensive services the enrolled child received against the required four years of intensive services regardless of whether Security Health Plan had covered those services. Security Health Plan may also require documentation including medical records and treatment plans to verify any evidence-based behavioral therapy the insured received for autism spectrum disorders that were provided to the enrolled child before age 9. Travel time for qualified health care providers, supervising health care providers, professionals, therapists or paraprofessionals is not included. Security Health Plan is not required to reimburse for travel time. Security Health Plan requires that progress be assessed and documented throughout the course of treatment. Security Health Plan may request and review the enrolled child’s treatment plan and the summary of progress on a periodic basis.

NON-INTENSIVE SERVICES
An enrolled child who has a verified diagnosis of autism spectrum disorder will be covered for non-intensive services that are evidence-based and provided by a qualified health care provider, professional, therapist or paraprofessional. Non-intensive services should be designed to sustain and maximize gains from intensive services or provided to an enrolled child who has not and will not receive intensive services.

Benefits will be provided for evidence-based therapies that:

- Are based upon a treatment plan developed by a qualified health care provider, supervising health care provider, professional or therapist for specific therapy goals that are clearly defined,
directly observed and continually measured while addressing autism spectrum disorders. Treatment plans must require that the enrolled child be present and engaged in the intervention. See Intensive Services for information on health care providers, professionals, therapists and paraprofessionals

- Are implemented by qualified health care providers, qualified supervising health care providers, qualified professionals, qualified therapists or qualified paraprofessionals
- Are provided in an environment most conducive to achieving the goals of the enrolled child’s treatment plan
- Are included with training and consultation, professional team meetings, and active involvement from the enrolled child’s family to implement the therapeutic goals developed by the team
- Are overseen by qualified supervising health care providers of the health care providers, professionals, therapists and paraprofessionals on the treatment team

Non-intensive level services may include direct or consultative services when provided by qualified health care providers, qualified supervising health care providers, qualified professionals, qualified paraprofessionals or qualified therapists. Security Health Plan requires that progress be assessed and documented throughout treatment. Security Health Plan also may periodically request and review the enrolled child’s treatment plan and summary of progress.

Travel time for qualified health care providers, qualified supervising health care providers, qualified professionals, qualified therapists or qualified paraprofessionals is not included when calculating the number of hours of care provided per week. Security Health Plan is not required to reimburse for travel time.

Intensive-level and non-intensive level services include but are not limited to speech, occupational and behavioral therapies.

Not covered
The following services are not covered under autism spectrum disorders:

- Acupuncture
- Animal-based therapy including hippotherapy (horse-riding therapy)
- Auditory integration training (sensory stimulation to improve brain processes)
- Chelation therapy (removing heavy metals from the body)
- Child care fees
- Cranial sacral therapy (massages intended to release tension and improve body movement)
- Custodial or respite care
- Hyperbaric oxygen therapy
- Special diets or supplements
- Pharmaceuticals and durable medical equipment
- Treatments in schools that are not related to the goals of the treatment plan or duplicate services provided by a school
- For therapy, treatment or services when provided to a member who is residing in a residential treatment facility, inpatient treatment or daytreatment facility
- The cost for the facility or location when treatment, therapy or services are provided outside a member’s home

BARIATRIC SURGERY/OBESITY TREATMENT
Security Health Plan generally does not cover weight loss surgery and weight loss programs.

Not covered
- Any obesity treatments such as anti-obesity drugs and surgeries
- Nutritional supplements
- Services for obesity, weight reduction, dietetic control or morbid obesity; weight-management programs and related medical lab and education services; and appetite suppressants
BLOOD AND BLOOD PRODUCTS
Covered
Human-derived and manufactured blood and blood products.

Not covered
Blood and blood products provided through a directed donor program.

CARDIAC REHABILITATION
Covered
• Phase I (inpatient) services
• Phase II services members receive at a facility with a certified cardiac rehabilitation program when the member has a recent history of:
  ○ Heart attack (myocardial infarction)
  ○ Coronary bypass surgery
  ○ Onset of angina pectoris (a heart condition marked by chest pain due to reduced oxygen to the heart)
  ○ Onset of unstable angina (irregular angina pectoris)
  ○ Heart valve surgery
  ○ Percutaneous transluminal angioplasty (a type of balloon angioplasty)
  ○ Any condition for which we determine cardiac rehabilitation to be appropriate treatment

Limitations
Coverage for Phase II cardiac rehabilitation is limited to 36 visits per year.

Not covered
Phase III and IV cardiac rehabilitation services including:
• Supervised exercise programs
• Preparation for returning to work and recreational activities
• Education and counseling
• Home exercise programs that target health promotion and risk factors

CHIROPRACTIC SERVICES
Covered
• Treatments that are expected to yield significant improvement in a member’s conditions
• Manipulative therapy

Not covered
Security Health Plan considers the following chiropractic or diagnostic procedures experimental and investigational. We 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
• Directional non-force technique
• Koren specific technique
• 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
• Sacro-occipital technique
• Spine-adjusting devices (ProAdjuster, PulStarFRAS, Activator)
• Thermography
• Upledger technique and cranial sacral therapy
• Webster technique (for breech babies)
• Whitcomb technique
CLINICAL TRIALS
Ask your health care provider to request prior authorization from Security Health Plan before you receive services related to clinical trials. Security Health Plan must determine that a clinical trial meets the criteria listed below.

Covered
Routine patient-care costs incurred during participation in a qualifying clinical trial.

Routine patient costs include items, services and drugs provided to you in connection with a qualified clinical trial that would be covered under this plan if you were not enrolled in such qualified clinical trial, provided that you were eligible to participate in the qualified clinical trial according to the trial protocol with respect to the treatment of cancer or other life-threatening disease or condition and either:

• The referring participating provider has concluded that your participation in the qualified clinical trial is appropriate according to the trial protocol; or
• You provide medical and scientific information establishing that your participation in the qualified clinical trial is appropriate according to the trial protocol

Routine patient care does not include:
• The investigational item, device 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
• A service that is clearly inconsistent with widely accepted and established standards of care for your diagnosis

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 Food and Drug Administration
• The study or investigation is a drug trial that is exempt from having such an investigational new drug application
CONGENITAL HEART DISEASE SURGERIES
Congenital heart disease (CHD) surgical procedures include, but are not limited to, surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels, and hypoplastic left or right heart syndrome.

Security Health Plan has specific guidelines regarding benefits for congenital heart disease services. Contact Security Health Plan Customer Service at 1-800-472-2363 or shpcs@securityhealth.org for information about these guidelines.

CONTRACEPTIVE DRUGS AND DEVICES
Drugs or devices approved by the U.S. Food and Drug Administration to prevent pregnancy.

Covered
• Contraceptives prescribed by a health care 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 percent. Name-brand contraceptives are covered at 100 percent when no generic is available. Copays, coinsurance and deductibles apply to name-brand contraceptives when generic alternatives are available.

Not covered
• Over-the-counter contraceptives unless Food and Drug Administration approved and prescribed for a woman by her health care provider
• The morning-after pill unless prescribed by a health care provider
• Male condoms

COSMETIC/RECONSTRUCTIVE SURGERY
Ask your health care provider to request prior authorization from Security Health Plan at least 14 days before all elective outpatient or inpatient reconstructive surgeries and procedures that treat a medical condition or improve or restore physiologic function.

Covered
Reconstructive procedures that treat an injury, sickness or birth defect are covered with prior authorization. The primary result of the procedure should not be a changed or improved physical appearance.

Reconstructive procedures include breast reconstruction after a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women’s Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other covered health service. Contact Security Health Plan Customer Service at 1-800-472-2363 or shpcs@securityhealth.org for more information about benefits for mastectomy-related services.

Not covered
Cosmetic procedures are excluded from coverage. Procedures that correct a birth defect without improving or restoring physical functions are considered cosmetic procedures. Psychological and social problems caused by injuries, illnesses or birth defects do not classify resulting surgeries and procedures as reconstructive procedures. Procedures that are not covered include:

• Pharmacological regimens, nutritional procedures or treatments
• Scar or tattoo removal or revision procedures such as salabrasion, chemosurgery and other such skin-abrasion procedures
• Skin-abrasion procedures performed as acne treatments
• Liposuction or removal of fat deposits
• Any treatment to improve skin appearance
• Spider vein treatments
• Hair removal or replacement
• Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures to remove excess fat or tighten skin in the abdomen or from under arms
• Medical and surgical treatment of excessive sweating (hyperhidrosis)
• Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy
• Treatment of benign gynecomastia, abnormal breast enlargement in males
• Breast reduction except as covered by the Women’s Health and Cancer Rights Act of 1998

DENTAL CARE – HOSPITAL AND AMBULATORY SURGERY CHARGES AND ANESTHESIA

Covered
Security Health Plan covers hospital or ambulatory surgery charges and anesthetics related to dental care provided in a hospital or ambulatory surgery center if any of the following apply:

• The member is a child younger than 5
• 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

DENTAL REPAIR OF SOUND NATURAL TEETH DUE TO COVERED ACCIDENTAL INJURY

Dental services to repair damage caused by accidental injury must begin within three months of the accident and be completed within 12 months of the accident

Covered
• Emergency examination
• Medically necessary diagnostic X-rays
• Endodontic (root canal) treatment
• Temporary splinting of teeth

Not covered
• Prefabricated post and core
• Simple minimal restorative procedures (fillings)
• Extractions
• Post-traumatic crowns, if such are the only clinically acceptable treatment

DIABETES TREATMENT

Covered
• The installation and use of an insulin infusion pump, and all other equipment and supplies, including insulin and other prescription medications, used in the treatment of diabetes
• Diabetic disease-management education programs that have been approved by Security Health Plan. See the Member Handbook or call Customer Service at 1-800-472-2363 for more information
• Diabetic supplies dispensed by network pharmacies

Limitations
• The purchase of one preferred pump (or a non-preferred pump with prior authorization) per member per calendar year
• You must see a network endocrinologist and use the pump for at least 30 days before the pump is purchased
DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES
Ask your health care provider to request prior authorization from Security Health Plan before you receive services related to durable medical equipment and medical supplies.

If more than one piece of durable medical equipment can meet the member’s functional needs, benefits are available for the equipment that meets minimum specifications. If a member rents or buys a piece of durable medical equipment that exceeds this guideline, the member will be responsible for any cost difference between the piece the member rents or buys and the piece Security Health Plan determines is the most cost-effective.

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

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. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage
• Mechanical equipment necessary for the treatment of chronic or acute respiratory failure except air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, which are personal comfort items
• Burn garments
• Insulin pumps and all related necessary supplies

Covered
• Enteral feeding supplies
• Ostomy supplies limited to pouches, face plates and belts, irrigation sleeves, bags and ostomy irrigation, catheters and skin barriers
• Orthopedic braces and splints
• Rental or purchase of equipment as determined by Security Health Plan such as, but not limited to, standard wheelchairs, hospital-type beds and artificial respiratory equipment
• Other medical equipment and supplies as determined by Security Health Plan

Benefits under this section also include speech-aid devices and tracheo-esophageal voice devices required to treat severe speech impediments or a lack of speech directly attributed to sickness or injury. Benefits for the purchase of speech-aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period.

Limitations
Benefits under this section do not include any device, appliance, pump (excluding an insulin pump), machine, stimulator or monitor that is fully implanted into the body. Security Health Plan will decide whether the equipment should be purchased or rented. Benefits are available for repairs and replacement, except when:
• Repairs and replacements are needed because of damage caused by misuse or neglect
• Items are lost or stolen

Not covered
• Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items not listed
• Routine maintenance and replacement of equipment because of abuse and neglect
• Durable medical equipment and medical supplies for your comfort, personal hygiene, convenience or athletics-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
• Orthotics for work-related and athletic-related conditions or purposes of participation in athletic activities, fitting and training of orthotics, shoe inserts that can be purchased over the counter and/or without a prescription
• Home testing and monitoring supplies and equipment, except as authorized by Security Health Plan

EMERGENCY SERVICES
Network hospital emergency rooms should be used whenever possible. If a member is unable to reach a network provider, the member should go to the nearest appropriate medical facility. If a member must go to a non-network provider for care, the member should call Security Health Plan as soon as possible to report where the member is receiving emergency medical care. Follow-up care must be received from a network provider, unless otherwise authorized by Security Health Plan. Emergency care received from a non-network provider will be covered at the same level of benefits as services provided by a network provider. Benefits are subject to copayment, coinsurance, deductible and other provisions of your policy.

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 copayment will apply to both sites of service.

Covered
• Network and non-network hospital emergency rooms
• Professional services with licensed medical health care providers
• Diagnostic services including laboratory and radiology services

Not covered
• Follow-up care received from a non-network health care provider, unless prior authorized by Security Health Plan
• Take-home drugs and supplies dispensed by the hospital at the time of hospital discharge for use at home. This includes discharge from emergency or urgent care visits

EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN SERVICES
Experimental and/or investigational and unproven services, and all related services, are generally not covered. The fact that an experimental and/or investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits. This exclusion does not apply to services provided during a clinical trial for which benefits are provided as described under Clinical Trials.

HABILITATIVE THERAPY
Ask your health care provider to request prior authorization from Security Health Plan before you receive services related to habilitative therapy.

Habilitative therapy includes services provided by a licensed physical therapist, physical therapy assistants occupational therapist or speech therapist for conditions that have significantly limited normal motor or speech development. For enrolled children, care must be delivered pursuant to a treatment plan to enhance a child’s ability to function with a congenital, genetic or early acquired disorder. This includes, but is not limited to, hereditary disorders. An early acquired disorder refers to a disorder resulting from a congenital or genetic cause that is present at or near the time of birth.
from illness, trauma, injury or some other event or condition suffered by an enrolled child before that enrolled child develops functional life skills such as, but not limited to, walking, talking or self-help skills.

To be considered habilitative, measurable functional improvement and progress must be made toward achieving functional goals appropriate to a member’s age within a predictable period of time. Examples of goals include rolling, crawling, pulling to stand, assisted or independent ambulation, dressing and feeding skills. The initial or continued treatment must be medically necessary and therapeutic, not experimental or investigational.

To be eligible for habilitative physical, speech, physical therapy assistant or occupational therapy services, evaluations must include standardized, age-appropriate tests that document a condition or developmental delay that affects activities of daily living, fine motor skills, or gross motor functionality shown to be below-average functionality for the member’s age. Age-equivalency scores will be accepted to meet criterion. The delay must be equivalent to a 25 percent delay based upon the age of the enrolled child in months.

Treatment plans are required and must address the following:

• When care starts, health care provider monthly summaries of ongoing treatment are required and should contain specific documentation regarding progress toward goals. Quarterly re-evaluations are required to document functional progress and the continued need for therapy. All may be submitted to Security Health Plan for review and coverage decisions regarding the medical necessity of ongoing care
• For continued habilitative therapy coverage, there must be a significant delay, below-average functioning for fine and gross motor skills, and a measurable functional improvement
• A discharge plan, with proposed treatment duration, must be submitted that demonstrates plans to wean services once no measurable functional improvement is demonstrated
• For members no longer meeting coverage criteria, a weaning process of three to six months will occur. If regression in function occurs, services will need to be re-evaluated for coverage
• Oral/motor, feeding and swallowing problems are considered rehabilitative, and are evaluated for coverage under the rehabilitative benefit

Limitations
• Coverage does not apply to services that are solely educational or otherwise paid under state or federal law for educational services
• Physical therapy, occupational therapy and speech therapy, one evaluation and three treatment sessions per method of treatment

Not covered
• Group therapy
• Educational therapy
• Social skills
• Therapy when measurable functional improvement is not expected or progress has plateaued
• Vocational and community reintegration services
• Activities of daily living training
• Services that address cognitive aspects of communication, including but not limited to attention, memory, problem solving and executive functions
• Services that address fine or gross motor skills typically acquired after the member’s age
• Equine or hippotherapy (horse-riding therapy)
• Services related to non-covered items, such as augmentative communication devices
• Accent/dialect reduction
• Vocal therapy
• Services provided in a school
HEARING AIDS, COCHLEAR IMPLANTS AND RELATED TREATMENT

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

Benefits under this section include hearing aids for enrolled children younger than 18 as required under Wisconsin insurance law.

**Covered**
- Hearing aids and cochlear implants that are prescribed by a physician, or by a licensed audiologist, in accordance with accepted professional, medical or audiological standards
- Treatment related to hearing aids and cochlear implants, including procedures for the implantation of cochlear devices
- Bone-anchored hearing aids are excluded except when either of the following applies: For members with head or face anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid and for members with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid
- Repairs and/or replacement for a bone-anchored hearing aid for members who meet the above coverage criteria, other than those covered under a manufacturer’s warranty

**Limitations**
- Hearing aids limited to one every three years
- Cochlear implants and bone-anchored hearing aids limited to one per lifetime

**Not covered**
Hearing-aid batteries and cords

HOME CARE SERVICES

Ask your health care provider to request prior authorization from Security Health Plan before you receive home care services.

Home health agency services that are ordered by a physician and provided in the member’s home by a registered nurse, home health aide or licensed practical nurse who is supervised by a registered nurse qualify as home care services. Services must be provided by a licensed home care agency.

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. A service will not be determined to be skilled simply because there is not an available caregiver.

**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. The services must be supervised by a registered nurse
- Physical, respiratory, occupational or speech therapy
- Medical supplies and laboratory services if needed under the home care services plan and ordered by a physician
- Nutrition counseling provided or supervised by a registered or certified dietitian when part of the home care services plan

**Limitations**
Benefits are limited to 60 visits per year.

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 is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
• It requires clinical training in order to be delivered safely and effectively.
• It is not custodial care.
• Coverage for home care service visits is limited to the number of visits per calendar year shown in the member’s Schedule of Benefits. Each visit by a person providing services under a home care services plan, evaluating the member’s 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.
• Coverage is limited to cases where hospitalization or skilled nursing facility confinement would be necessary if a home care service was not provided.
• 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 as determined by Security Health Plan.
• The necessary care cannot be provided by the patient’s family or others residing with the patient.

Not covered
Home care services provided by the member’s family or others residing with the member.

HOME INFUSION
Ask your health care provider to request prior authorization from Security Health Plan before you receive services related to home infusion.

Home infusion includes therapeutic treatments received on an outpatient basis at a hospital, physician’s office or home setting. It includes but is not limited to intravenous infusion.

Covered
• Intravenous (IV) therapy ordered by a physician and performed in the member’s home as approved by Security Health Plan.
• Medical-education services that are provided in the member’s home by appropriately licensed or registered health care professionals when:
  ◦ Disease education for patient self-management is an important component of treatment.
  ◦ A member needs a trained professional to teach him or her about a disease.

HOSPICE CARE
Ask your health care provider to request prior authorization from Security Health Plan before you receive services related to hospice care.

Hospice care that is recommended by a physician provides comfort and support services for members who are near the end of their lives. Hospice care includes physical, psychological, social, spiritual and respite care for those near death and short-term grief counseling for immediate family members while the member is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency. 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 and Security Health Plan-approved hospice facility or agency, or by any other facility, and approved in advance by Security Health Plan.

Covered
• Services and supplies for pain control and other acute and chronic symptom management.
• Part-time or intermittent nursing care by a registered nurse, licensed practical nurse or home health aide for up to eight hours in any 24-hour period.
• Medical social services under the direction of a physician. These include assessment of a member’s social, emotional and medical needs, and the home/family situation; identification of community resources available to the member; and help obtaining resources to meet the member’s needs
• Psychological counseling
• Dietary counseling
• Consultation or case-management services by a physician
• Medical supplies prescribed by a physician
• Respite care
• Drugs and medicines while the member is confined in a hospice facility
• Services of the following health care providers, but only if the health care provider is an employee of a hospice care agency and such agency retains responsibility for the member’s care: a physician for consultation or case management services; and a physical or occupational therapist
• Any service provided by a health care professional that, after instruction and demonstrated competence, can be reasonably and safely performed by the member or the member’s family. Examples include, but are not limited to, routine insulin injection, self-urinary catheterization, general range-of-motion exercises, wound care for non-infected post-operative or chronic medical conditions and long-term feeding by gastrostomy or jejunostomy tube

Not covered
• Financial or legal counseling, including estate planning or drafting of a will
• Homemaker or caretaker services that are not solely related to the member’s care including, but not limited to, sitter or companion services for the member or the member’s family; transportation; house cleaning; or physical maintenance of the house
• Pastoral counseling or funeral arrangements

INFERTILITY SERVICES
Not covered
• Any services to evaluate fertility or infertility or to restore, enhance or promote fertility. This includes medical, surgical, mental health, pharmacologic, laboratory or radiology and all other services for this purpose. The diagnosis of infertility alone does not constitute an illness
• In vitro fertilization, gamete intrafallopian transfer (GIFT), and related or similar services, regardless of reason or diagnosis
• Reversal of sterilization surgery

INPATIENT HOSPITAL SERVICES
Inpatient certification from Security Health Plan is required. The health care provider is required to contact Security Health Plan at least 14 days before all elective inpatient surgeries. 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. 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, and services and supplies
  ◦ Intensive care unit room and board
  ◦ Hospital services in connection with childbirth for no less than 48 hours after vaginal delivery or 96 hours after cesarean delivery unless the attending health care provider, after consultation with the mother, discharges the mother and/or newborn earlier

Not covered
• Take-home drugs and supplies dispensed by the hospital
• Hospital stays that are extended for reasons other than medical necessity (such as lack of
transportation, lack of caregiver or inclement weather)
• A continued hospital stay, if the attending physician has documented that care could effectively be provided in a less acute care setting (such as a skilled nursing facility or member’s home)
• Separate charges for personal comfort or convenience items
• Any portion of a hospital stay that is not medically necessary as determined by Security Health Plan

KIDNEY DISEASE
Covered
Inpatient and outpatient kidney-disease treatment including dialysis, transplantation and donor-related services.

MATERNITY SERVICES
Inpatient certification from Security Health Plan is required for any inpatient admissions. A member’s health care provider must contact Security Health Plan in advance.

Covered
• The prenatal, delivery and postnatal care performed by an obstetrical health care provider
• Additional prenatal visits for high-risk pregnancy performed by an obstetrical health care 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
• Water delivery/birth
• Services performed by non-obstetrical health care providers
• Services performed by a certified nurse midwife

Not covered
• Prenatal cradle (maternity belt)
• Home delivery and home visits
• Services performed by a licensed midwife or certified professional midwife
• Services performed solely to determine gender
• Abortion procedures to end a pregnancy except as specifically stated above

MENTAL HEALTH AND SUBSTANCE-ABUSE SERVICES
Ask your health care provider to request prior authorization from Security Health Plan before you receive mental health and substance-abuse services.

Covered
• Inpatient hospital services including:
  ◦ Treatment of nervous or mental disorders, alcoholism or drug abuse
  ◦ Treatment of alcoholism or drug abuse in a facility with a program certified by the Department of Health Services
  ◦ Inpatient detoxification if services are considered medically necessary

• Outpatient services including non-residential services for the treatment of nervous or mental disorders, alcoholism or drug abuse problems for the purpose of enhancing treatment. Treatment must be provided by any of the following:
  ◦ A program in an outpatient treatment facility if the program and facility are approved by the Department of Health Services and established and maintained according to Wisconsin Statutes
  ◦ A licensed physician who has completed a residency in psychiatry
  ◦ A licensed psychologist
  ◦ A licensed mental health professional practicing within the scope of his or her license and applicable rules

• Coverage of up to five visits outside the service area for full-time students with prior authorization. An enrolled child who is a full-time student attending school outside the service area, but in Wisconsin will have coverage for limited outpatient services received from
non-network health care providers for alcoholism, drug abuse, and mental and nervous disorders. Services may include a clinical assessment of the problem and follow-up treatment.

- Transitional services including treatment of nervous or mental disorders, alcoholism or drug abuse that is provided in a less-restrictive manner than inpatient hospital services but in a more-intensive manner than outpatient services if both the program and the facility are approved by the Department of Health and Human Services:
  - Mental-health services for enrolled adults, children and adolescents in a day-treatment program offered by a network health care provider certified by the Department of Health Services
  - Services for people with chronic mental illness provided through a community support program certified by the Department of Health Services
  - Residential treatment programs certified by the Department of Health Services for alcohol- and drug-dependent people
  - Services for alcoholism and other drug problems provided in a day-treatment program certified by the Department of Health Services
  - Intensive outpatient programs for the treatment of psychoactive substance-use disorders provided in accordance with the patient placement criteria (American Society of Addiction Medicine)
  - Coordinated emergency mental-health services for people who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided. Services must be provided by a program certified by the Department of Health Services for the period of time the person is experiencing a mental-health crisis until the person is stabilized or referred to other health care providers for stabilization.

Not covered
- Non-network health care provider services if Security Health Plan determines that treatment will prevent a student from attending school on a regular basis or the student is no longer enrolled in the school. For students completing up to five visits as noted above, coverage is not available for continuing care by the non-network health care provider unless approved by Security Health Plan.
- Marriage counseling
- Hypnotherapy
- Halfway houses
- Residential mental health care services for mental health conditions such as but not limited to eating disorders, depression, anxiety and obsessive compulsive disorders
- Services or supplies for the diagnosis or treatment of alcoholism or substance-use disorders that, in Security Health Plan’s judgment, are:
  - Not consistent with generally accepted standards of medical practice for treating such conditions
  - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and are therefore considered experimental.
  - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective
  - Not consistent with Security Health Plan’s level of care guidelines or best practices as modified from time to time
  - Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the member’s mental illness, substance-abuse disorder or condition based on generally accepted standards of medical practice and benchmarks.
NUTRITION COUNSELING AND EDUCATION VISITS

Covered
Up to four nutrition counseling visits by a registered dietitian per calendar year.

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
- Weight-management services
- Services for obesity, weight reduction, dietetic control or morbid obesity, weight-management programs and related medical, lab and education services and appetite suppressants, except as specifically authorized by Security Health Plan
- Weight-management patient and health-education programs except when specifically authorized by Security Health Plan

NUTRITIONAL SUPPORT

Covered
- Enteral feedings, if they are the sole source of nutrition
- Infant formula. Coverage of amino acid-based formulas will be considered for infants up to 1 year old with demonstrated formula-protein intolerance (both milk and soy), cystic fibrosis, amino acid, organic acid, fatty acid, metabolic or malabsorption disorders
- Amino acid-based formulas (Neocate, Elecare, Nutramigen AA)

OFFICE VISITS AND OUTPATIENT CARE BENEFITS

Covered
- Professional services provided in a physician’s office
- Services provided in other outpatient settings when they are medically necessary and appropriate to diagnose or treat illness or injury
- Members in some plans may qualify for one visit per year with their primary care provider with no cost sharing. The member must identify his or her primary care provider on record with Security Health Plan in advance by calling 1-800-472-2363. Members should consult their Schedule of Benefits to determine whether they qualify. Any services outside the office visit including labs and X-rays are subject to member cost sharing

OUTPATIENT HOSPITAL AND SURGICAL SERVICES

Covered
- Medically necessary services as prescribed by a health care provider unless otherwise excluded
- 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
- Treatment of physical complications at all stages of the mastectomy including lymphedema (swelling caused by lymphatic fluid)
- Services required to repair a defect caused by an injury to achieve an acceptable cosmetic result, as determined by Security Health Plan
- Services to repair a birth defect that caused functional impairment in an enrolled child
- Reconstructive surgery that is medically necessary or when coverage is required by law

OUTPATIENT THERAPIES (PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY; REHABILITATIVE CARE)

Ask your health care provider to request prior authorization from Security Health Plan before you receive services related to outpatient therapies such as physical therapy, speech therapy, occupational therapy and rehabilitative care.

Rehabilitation services must be performed by a physician or a licensed therapy provider. Benefits under this section include rehabilitation services
provided at a physician’s office or on an outpatient basis at a hospital or alternate facility.

Benefits can be denied or shortened for covered members who are not progressing in goal-directed rehabilitation or if rehabilitation goals have been met.

Please note that Security Health Plan will pay benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer or a birth defect. For speech therapy related to autism spectrum disorders, please refer to the services described under Autism Spectrum Disorders in this section.

Covered
Therapy performed by a physician; licensed physical, speech or occupational therapist; or any other health care provider approved by Security Health Plan.

Limitations
Speech therapy is limited to 20 visits per year. Occupational therapy and physical therapy are limited to 40 visits per year.

Not covered
• Services that are not for or related to the treatment of an illness or injury
• Services that continue after the member reaches the expected state of improvement, resolution or stabilization of a health condition as determined by Security Health Plan
• Treatment provided by athletic trainers
• Physical therapy, speech therapy, occupational therapy and/or complementary therapy for the following conditions:
  ◦ Learning disabilities
  ◦ Developmental delay, regardless of cause
  ◦ Perceptual disorders
  ◦ Intellectual disabilities or related conditions
  ◦ Behavior disorders
  ◦ Multiple handicaps
  ◦ Sensory deficit
  ◦ Motor dysfunction
  ◦ Communication or articulation disorders including apraxia, dyspraxia and pervasive developmental disorders
• Services that 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 such as:
  ◦ Recreational therapy
  ◦ Therapy that is primarily educational
  ◦ Physical fitness
  ◦ Phase III and IV cardiac rehabilitation or exercise programs
• Maintenance therapy including but not limited to maintenance chiropractic or physical therapy care
• Rehabilitation services and manipulative treatment to improve general physical conditions that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including but not limited to routine, long-term or maintenance/preventive treatment
• Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work)
• Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter
• Lab services associated with functional capacity evaluation/test
• Treatment rendered by athletic trainers

PEDICATRIC DENTAL
This policy does not include pediatric dental services as required under the Affordable Care Act. This coverage is available at the Health Insurance Marketplace and may be bought as a stand-alone product. Please contact Security Health Plan or the health insurance Marketplace if you want to buy pediatric dental coverage or a stand-alone dental-services product.
PRESCRIPTION DRUG COVERAGE
Certain drugs, as shown on the current formulary and at securityhealth.org/formulary, require prior authorization from Security Health Plan. Ask your health care provider to request prior authorization from Security Health Plan before you receive those drugs.

Covered
The following prescription drugs that are medically necessary and dispensed by a pharmacist at a network pharmacy, subject to the deductible, copayment and/or coinsurance shown in the member’s Schedule of Benefits:

- A U.S. Food and Drug Administration-approved drug included on the current formulary. See our website at www.securityhealth.org/formulary to view the most up-to-date formulary
- A compounded medication that is not otherwise excluded under a member’s coverage and contains at least one FDA-approved prescription drug for which, in Security Health Plan’s determination, a commercially available alternative does not exist
- Oral contraceptives for birth control when dispensed by a health care provider
- Maintenance medications taken on a regular basis (typically daily) for a chronic medical condition. Most medications will be available in maintenance quantities if allowed in the Schedule of Benefits. Injectable medications, other than insulin, are not considered maintenance medications and are not covered in maintenance quantities
- Specialty prescription drugs which are generally high-cost, self-administered biotechnology drugs used to treat patients with certain illnesses. If the member requires specialty prescription drugs, Security Health Plan may direct the member to a designated pharmacy with which we have an arrangement to provide these prescription drugs. The member may access a complete list of specialty prescription drugs through the Internet at www.securityhealth.org/formulary

Limitations
- Security Health Plan reserves the right to limit coverage of daily dosing regimens to FDA-approved dosing as defined by the manufacturer and clinical best-practice guidelines
- For prescriptions not submitted electronically, any amounts in excess of the contracted charge for that drug
- Supplies of prescription drugs exceeding $1,500 require approval from Security Health Plan before being dispensed. In such cases, Security Health Plan may limit quantities dispensed to a one-month supply or less as applicable to the medication and the intended course of treatment
- Non-formulary drugs when an exception is requested by the health care provider. The request should include the member name; health care provider’s name, address and telephone number; drug strength, dosage form and directions; diagnosis; lab medical data; and the medical reason for the request. Written requests should be sent to:
  Security Health Plan
  ATTN: Pharmacy Services
  PO Box 8000
  Marshfield, WI 54449-8000

Not covered
- Prescription drugs dispensed by non-network pharmacies except in cases of urgent or emergent care
- Prescription drugs not found on the current version of the formulary, unless otherwise listed in the member’s Schedule of Benefits or an exception has been granted upon a request from the member’s health care provider
- Medications administered in a physician’s office (and/or associated fees) that could be safely self-administered or have oral or other
alternatives that could be safely self-administered
• Products that are not considered safe for self-administration by the layperson as determined by Security Health Plan including, but not limited to products administered by an injection into a muscle unless specifically included on the current formulary
• Devices, appliances or durable medical equipment. Refer to the Durable Medical Equipment description for coverage of these items
• Drugs or devices available over the counter that do not require a prescription order, unless Security Health Plan has designated the over-the-counter medication as eligible for coverage on the current formulary and it is obtained with a prescription order from a physician
• Drugs completely consumed or administered at the time and place of the health care provider who dispenses the drug(s) because they are covered under a medical benefit
• Prescription drugs applied, ingested or administered while the member is a patient or resident in a licensed hospital, mental-health facility, extended-care facility, convalescent hospital, skilled nursing facility or a similar institution, or in any other situation where medications have not been dispensed in conventional dispensing packages for home use or where the member has surrendered control and possession of his/her medications to an institution
• Drugs available over the counter that do not require a prescription order, unless we have designated the over-the-counter medication as eligible for coverage on the current formulary and it is obtained with a prescription order from a physician
• Prescription drugs as a replacement for a prescription drug that was lost, stolen, broken or destroyed
• Prescription drugs relating to non-covered services, procedures or treatments
• Prescription drugs for appetite suppression or weight loss
• Prescription drugs that are not medically necessary, including drugs used for cosmetic purposes or athletic-performance enhancement
• Growth hormone for enrolled children with familial short stature (short stature based on heredity and not caused by a diagnosed medical condition)
• Prescription drugs dispensed for an amount that exceeds the supply limit (days’ supply or quantity limit)
• Prescription drugs dispensed outside the United States, except as required for emergency treatment
• New drugs during the first six months after U.S. Food and Drug Administration approval and commercial availability unless specifically included on the current formulary
• Drugs that Security Health Plan has formally reviewed and determined not to cover including but not limited to drugs that are the main active metabolites, the racemic form or an alteration of an existing product already on the current formulary
• Combination products when the components of the combination product are covered separately, unless the combination product is specifically included on the current formulary
• Prescription drugs packaged with an over-the-counter medication in a kit, unless the kit is specifically included on the current formulary
• Drugs for which benefits are paid elsewhere under a member’s coverage

PREVENTIVE CARE SERVICES
Services for preventive medical care can be provided on an outpatient basis at a physician’s office, an alternate care facility 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 for a list of the most common services.
PROSTHETICS AND ORTHOTICS

Ask your health care provider to request prior authorization from Security Health Plan before you receive services or equipment related to prosthetics and orthotics.

Covered

- Prosthetic equipment. The prosthetic device must be ordered by, provided by, or used under the direction of a physician.
- External prosthetic devices that replace a limb or a body part, limited to artificial arms, legs, feet and hands, and artificial face, eyes, ears and nose.
- Breast prosthesis as required by the Women’s Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.
- External breast prosthesis after mastectomy.
- Orthotics that meet Security Health Plan’s coverage criteria.

RADIOLOGY AND LABORATORY SERVICES

Covered

- Services for illness and injury-related diagnostic purposes, received on an outpatient basis at a hospital or alternate care facility.
- Blood lead tests for enrolled children age 6 and younger.
- Services for computed tomography (CT) scans, positron emission tomography (PET) scans, magnetic resonance imaging (MRIs), magnetic resonance angiography (MRAs), nuclear medicine, and major diagnostic services received on an outpatient basis at a hospital or a physician’s office.
- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists when these services are performed at a physician’s office.

SKILLED NURSING CARE

Ask your health care provider to request prior authorization from Security Health Plan before you receive services related to skilled nursing care.

Skilled nursing care includes services and supplies provided during an inpatient stay at a skilled nursing facility or inpatient rehabilitation facility.

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. A service will not be determined to be skilled simply because there is not an available caregiver. Benefits can be denied or shortened for members who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Please note that benefits are available only if both of the following are true:

- If the initial confinement in a skilled nursing facility or inpatient rehabilitation facility was or will be a cost-effective alternative to an inpatient stay at a hospital.
- The member will receive skilled care services that are not primarily custodial care.

Skilled care is 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 is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training to be delivered safely and effectively.
Covered

- Skilled nursing care and/or skilled therapy prior approved by Security Health Plan before services are provided; skilled care received in a licensed skilled nursing facility for up to the number of days shown in your Schedule of Benefits
- Continuation of treatment for illness or injury when treatment began in a hospital if the member is admitted to a licensed skilled nursing facility within 24 hours after discharge from the hospital
- Supplies and non-physician services received during the inpatient stay
- Room and board in a semi-private room (a room with two or more beds)
- Physician services for anesthesiologists, consulting physicians, pathologists and radiologists

Limitations
Skilled nursing services limited to 30 days per confinement.

Not covered

- Skilled nursing care and/or skilled therapy not prior approved by Security Health Plan
- Leave-of-absence days
- Respite care
- Custodial care
- Care exceeding the number of days shown in the member’s Schedule of Benefits

TEMPOROMANDIBULAR DISORDERS (ALSO KNOWN AS TEMPOROMANDIBULAR JOINT DISORDERS, TMJ)

Covered

- Diagnostic procedures and medically necessary surgical or nonsurgical treatment for the correction of functional deformities of the maxilla or mandible if all of the following apply:
  - The condition is caused by congenital, developmental or acquired deformity, disease or injury
  - Under the accepted standards of the profession of the health care provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition
  - The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction
- Nonsurgical treatment including prescribed intraoral splint therapy devices

Not covered

- Cosmetic or elective orthodontic care
- Periodontal care
- General dental care
- Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury, dislocation, cancer or temporomandibular joint disorder
- Orthognathic surgery jaw alignment, except as a treatment of obstructive sleep apnea

TELEHEALTH

Covered
Telemedicine/telehealth services are available through a network health care provider. Services must be provided at a physician’s office with a visual set-up.

Not covered
- Connection fee
- Computer or Internet consultations, visits or services

TRANSPLANTS

Ask your health care provider to request prior authorization from Security Health Plan before you receive services related to transplants. Unless otherwise shown in the member’s Schedule of Benefits, benefits are payable as follows.

Covered
- Transplant services that are medically necessary because of an injury or illness
Medically necessary organ or tissue transplant services for a recipient’s covered transplant procedure directly provided to the member by a designated transplant health care provider for the following:

- Bone marrow, organ and tissue donor searches and procurement fees
- Transplant evaluation at a transplant health care provider prior approved by Security Health Plan
- Licensed professional ambulance service for transporting the recipient
- All other transplant services directly provided to a recipient for each covered transplant procedure
- Donor-related services billed by the recipient’s designated transplant health care provider

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

URGENT CARE SERVICES

Covered

- Urgent care from a network health care provider
- Urgent care from a non-network health care provider if a network health care provider is not available

Not covered

- Care that can safely be postponed until the member returns to the service area
- Follow-up care received from a non-network health care provider unless prior authorized by Security Health Plan
- Take-home drugs and supplies dispensed by a hospital at the time of hospital discharge for use at home. This includes discharge from emergency or urgent care visits

VISION SERVICES

Eye Exams

Covered

- Adult:
  - One routine eye exam every two years including dilation/refraction, if professionally indicated
  - If diabetic, one routine exam annually
- Child:
  - One routine eye exam per year including dilation/refraction

Examples of covered eyewear include:

- Glasses
  - For enrolled dependents younger than 19, one pair of glasses including lenses and frames per year 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
  - Frames
  - Ultraviolet protective coatings, polycarbonate lenses, blended-segment lenses, standard or premium progressive lenses, intermediate vision lenses, photochromic glass lenses, plastic photosensitive lenses, polarized lenses, standard anti-reflective coatings, premium anti-reflective coatings, ultra anti-reflective coatings and hi-index lenses

Contact lenses
- For enrolled dependents younger than 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
• Eyewear for adults 19 and older
• 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
• Eyeglass or contact lenses except as defined above

SECTION IV – GENERAL EXCLUSIONS: WHAT’S NOT COVERED

In addition to specific exclusions and limitations identified in the 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 Customer Service at 1-800-472-2363 or shpcs@securityhealth.org to find out whether a specific service will be covered.

• 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 including, but not limited to, sublingual therapy
• Acupressure or acupuncture
• Aromatherapy
• Art therapy, music therapy, dance therapy, horseback-riding therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health
• Biofeedback
• Coma stimulation
• Cosmetic surgery
• Court-ordered care unless required by law
• Custodial or rest care; domiciliary care provided in a patient’s home to assist with bathing, eating, cleaning and preparing meals; maintenance/supportive care
• Dental or dental-related services, treatment or procedures not specifically covered under the Benefits section of this Policy
• Experimental and investigational services unless coverage is required by state or federal law
• Hair replacements or substitutions, including, but not limited to, wigs, prosthetic hairpieces, transplants and implants and hair restorations including, but not limited to, Minoxidil or Rogaine, for any reason
• 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, work-site and return-to-work evaluations, work hardening programs and all related material and products
• Hearing-aid batteries
• Hypnotherapy
• Illness or injury caused by atomic or thermonuclear explosion or resulting radiation; or any type of military action, friendly or hostile
• Indirect services provided by health care 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
• Infertility
• Lab services associated with functional capacity evaluations/tests
• Massage therapy
• Medical and surgical treatment of snoring, except when provided as part of treatment for documented obstructive sleep apnea
• Neuroeducation testing and training
• Private-duty nursing
• Professional services not provided by a physician or any of the health care providers listed in the Definitions section of this Policy
• Psychosurgery
• Rabies vaccine if no animal bite has occurred
• Rolfing (a massage technique aimed at the vertical realignment of the body, deep enough to release muscular tension at the skeletal level)
• Routine foot care that 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 and the cutting, trimming or other non-operative partial removal of toenails unless deemed medically necessary
• Services or supplies not medically necessary as determined by Security Health Plan
• Services that are not in accordance with accepted standards of medical practice or that have unproven efficacy as determined by Security Health Plan
• 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, adoption, child support and custody evaluations, immigration, licensing and certifications and/or settlement of lawsuits
• Services from health care 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 or anyone residing with the member
• 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
• Charges for missed appointments because of patient fault
• Services for which proof of claim is not provided to Security Health Plan in accordance with the “Proof of claim” heading in Section VII of this Policy
• Except for incidents involving domestic violence, 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
• 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 does not apply to a sole proprietor or partner who elects not to become an employee, if we are 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. See the How Our Coverage Works When You Have Medicare section of this Policy
• Services, such as public health services, furnished by any federal, state, county or city agency, or other similar entity when funding is available or the member is not liable for the costs in the absence of insurance, unless such coverage is required by any state or federal law
• Sex transformation surgery and services, including counseling for, or leading to, sex transformation surgery and sex hormones related to such surgery
• Travel, lodging, housekeeping, meal preparation or meal delivery
• Treatment, services and supplies for any injury or illness as a result of war, declared or undeclared, enemy action or action of Armed Forces of the United States, or any state of the United States or its allies, or while serving in the Armed Forces of any country

DEFINITIONS
Allowable expense – A necessary, reasonable and customary item of expense for health care. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense unless the patient’s stay in a private hospital room is medically necessary either in terms of generally accepted medical practice or as specifically defined in the plan. When a plan provides benefits in the form of services, the reasonable cash value of each service provided shall be considered both an allowable expense and a benefit paid.

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.

Plan – Any of the following that provides benefits or services for medical or dental care or treatment:

• Group insurance or group-type coverage, whether insured or self-funded, that includes continuous coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage
• Coverage under a governmental plan or coverage that is required or provided by law. This does not include Medicare and Medicaid. It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program
• Medical expense benefits, coverage in group, group-type and individual automobile “no-fault” contracts but, as to the traditional automobile “fault” contracts, only the medical benefits written on a group or group-type basis are included

Each contract or other arrangement for coverage under those listed above is a separate plan. If an arrangement has two parts and coordination of benefits rules apply only to one of the two, each of the parts is a separate plan.

SECTION V – WHEN MEMBERS HAVE MORE THAN ONE PLAN

APPLICABILITY
This section applies to this plan when a member or a member’s covered dependent has health care coverage under more than one plan. “Plan” and “this plan” are defined below.

The order of benefit determination rules 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 percent of the total allowable expense.
**Primary plan/secondary plan** – 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.

**This plan** – The part of the policy that provides benefits for health care expenses.

**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 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:

- **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 cover 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.
EFFECT ON THE BENEFITS OF THIS PLAN

• When this subsection applies:

This subsection applies when, in accordance with “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 these 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 COB 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 VI – HEALTH PLAN BUSINESS GUIDELINES

A MEMBER’S RELATIONSHIP WITH A PHYSICIAN, HOSPITAL OR OTHER HEALTH CARE PROVIDER

We will not interfere with the professional relationship a member has with a health care provider. We do not contract with members to choose or provide a health care provider, services or facilities, nor do we assure their availability. We are 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 including, but not limited to, any network health care provider. We are obligated only to provide the benefits stated in the coverage.

PHYSICIAN, 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. We will use individually identifiable information about a member as permitted or required by law, including in our operations and in our research. We 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
We pay network health care providers through various types of contractual arrangements, some of which 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 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 network health care providers receives a monthly payment from us for each member who selects a network health care provider within the group to perform or coordinate certain health services. The 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

We use various payment methods to pay specific network health care providers. From time to time, the payment method may change. If a member has questions about whether a network health care provider’s contract with us includes any financial incentives, we encourage that member to discuss those questions with his or her health care provider. The member may also contact us at 1-800-472-2363. We can tell a member whether a member’s 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 we 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 we recommend that members discuss participating in such programs with their health care providers. These incentives are not benefits and do not alter or affect a member’s benefits. Members may contact us with any question.

REBATES AND OTHER PAYMENTS
We may receive rebates for certain drugs that are administered to members in members’ homes, in a health care provider’s office, or at a hospital or alternate facility. This includes rebates for those drugs that are administered to members before members meet any applicable annual deductible. We do 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 percent of the total *allowed amount* for covered expenses.

**SUBROGATION AND WORKERS’ COMPENSATION**

1. **Workers’ compensation**
   If benefits are paid by Security Health Plan and we determine a member was eligible to receive workers’ compensation benefits for the same incident, we have the right to recover as described under the “Right of subrogation and reimbursement” provision in this coverage. We will 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 that they agree to reimburse Security Health Plan as described below.

2. **Right of subrogation and reimbursement**
   Immediately upon paying or providing any benefit under this coverage, we shall be subrogated to all rights of recovery a member or a member’s covered dependents have against any party potentially responsible for making any payment to a member because of a member’s injuries or other damages to the full extent of the benefits we provide under this coverage. As used in this provision, the term “responsible party” means any party potentially responsible for making any payment to a member or on a member’s behalf because of a member’s injuries or other damages, or any insurance coverage responsible for making such payment including, but not limited to:
   • 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 from any sources designed or intended to compensate a member for a member’s injuries sustained or illness suffered

We are 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, we are 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 prior written consent to 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 regardless of whether the settlement or judgment received by a member identifies the medical benefits we provided. We are 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. We are entitled to recover from any and all settlements or judgments, even 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 we have 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).

4. Member’s cooperation required
Neither the member nor the member’s dependents may do anything to prejudice our subrogation and reimbursement rights. The member may not enter into a settlement or compromise agreement with a responsible party without our prior written consent. A member will, when requested, fully cooperate with our efforts to recover the benefits we paid. Members will 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, because of injuries a member sustains. Members will include the benefits paid by Security Health Plan as part of the damages they seek to recover in any claim or legal action they file against any potentially responsible parties who caused injuries or illnesses. Members further agree to contact Security Health Plan to resolve our lien before any settlement or after any verdict, judgment or award. Failure to cooperate in this manner will be deemed a breach of contract, and may result in legal action against the member. Security Health Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

If a member or member’s dependents receive a recovery to which our lien applies, we maintain 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. We 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 we are 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 provided 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.

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:

1. 60 days after we have received or waived proof of claim; or
2. The date we deny 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 we require 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.

PROOF OF CLAIM

The member, or the health care provider on the member’s behalf, must submit to Security Health Plan written proof of the claim for each service within 90 days of the date on which the member received that service. Written proof of the member claim includes:

- The completed claim forms if required by Security Health Plan
- The actual itemized bill for each service
- All other information that we need to determine our liability to pay benefits under the coverage including, but not limited to, medical records and reports

In accordance with Wisconsin law, if circumstances beyond the member’s control prevent the member from submitting such proof to Security Health Plan within this time period, we will accept a proof of claim, if provided as soon as possible and within one year after the 90-day period. If we do not receive the written proof of claim required by Security Health Plan within that one-year-and-90-day period, no benefits are payable for that service.

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, this document, Schedule of Benefits, any amendments, the member’s application and any supplemental applications.
WAIVER AND CHANGE
Only the Security Health Plan chief administrative officer (CAO) or his or her designee can execute a waiver or change the coverage. No agent, broker or other person may waive or change any provision or extend the time for any premium payment. At our option, Security Health Plan may unilaterally change any term, condition, exclusion, limitation or other provision of the coverage if we send written notice to the policyholder at least 30 days in advance of that change. When the change reduces coverage provided, we must send written notice of the change to the policyholder at least 60 days before any such change takes effect. Each amendment is binding on subscribers, members and Security Health Plan. No error, including clerical errors, will invalidate coverage otherwise validly in force, continue or reissue coverage validly terminated or cause coverage to be issued which otherwise would not be issued by Security Health Plan. Upon discovery of any error, Security Health Plan will make, at its option, an equitable 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

We 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, we may, in our discretion, offer benefits for services that would otherwise not be covered. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

ADMINISTRATIVE SERVICES
We 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. We are 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, we reserve the right, in our sole discretion and without a member’s approval, to change, interpret, modify, withdraw or add benefits or 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 we specify
- 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

1. Direct payment of benefits
Unless otherwise stated in the coverage, we 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.

2. Recovery of excess payments
If we pay 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. We can also recover such payments from any other insurance company, service plan or benefit plan that has received them. If we 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. We 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. We will reduce benefits otherwise payable for such claims until we recover the excess benefit payments.

CLAIMS PROCESSING PROCEDURE

1. Filing a claim
In most cases, the health care provider submits claims directly to Security Health Plan. However, a member may also submit a claim. Claims should be submitted to Security Health Plan, PO Box 8000, Marshfield, WI 54449. See “Proof of claim” section for more information about filing a claim.

For purposes of this section, a correctly filed claim is one that includes the information in the “Proof of claim” section. An incomplete claim is a correctly filed claim that requires additional information including, but not limited to, medical information, coordination of benefits questionnaire or a subrogation questionnaire. An incorrectly filed claim is one that lacks information which enables Security Health Plan to determine what, if any, benefits are payable under the terms and conditions of the coverage. Examples include, but are not limited to, claims filed that are missing procedure codes, diagnosis information or dates of service.

2. Notice of claims denial
If, for any reason, a member’s claim is denied, in whole or in part, we will give the member a written notice containing the basis for the decision including, if applicable, information about internal rules, criteria and/or the scientific or clinical judgment for the decision; and any information necessary to complete the claim.

We will decide whether benefits are payable on the claims submitted to Security Health Plan within a reasonable period of time after we receive sufficient written proof of claim. Any benefits paid by Security Health Plan in accordance with coverage will fully discharge Security Health Plan from all further liability to the extent of benefits paid.

If benefits are payable, we will pay them as soon as reasonably possible directly to the hospital, physician or other health care provider providing such services. If the claim is denied in whole or in part, the member will receive a written notice from Security Health Plan with:

• The specific reason(s) on which denial or partial denial is based
• An explanation of how the member may have the claim reviewed by Security Health Plan if the member does not agree with our decision. Please see the next section, “Grievance Procedure.”
**GRIEVANCE PROCEDURE**

**Grievance** – Any dissatisfaction, written by or on behalf of a member, regarding Security Health Plan that affects health-benefit plan coverage or the administration of coverage. **Grievances** can include 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

Situations might occasionally arise when a member questions or is unhappy with some aspect of service received from Security Health Plan. For example, a member might question a claim decision under the coverage. Because most questions about benefits and plan operations can be resolved on an informal basis, we urge members first to try to resolve any problem by directly contacting the appropriate health care provider or Security Health Plan representative by calling Customer Service at 1-800-472-2363. If the matter cannot be informally resolved, a member (or anyone else on a member’s behalf) has the right to file a formal grievance with Security Health Plan. We have two procedures, one for situations requiring expedited review and one for all other situations. We will continue the member’s coverage pending the outcome of any grievance that uses this process.

**GRIEVANCE PROCESS**

*Note:* Members who purchase their Security Health Plan coverage on the American Health Benefits Exchange, also called the Health Insurance Marketplace or “Marketplace,” cannot appeal or grieve their disenrollment through Security Health Plan except in instances involving disenrollment due to premium nonpayment.

Each time we make an adverse benefit determination or initiate disenrollment proceedings, we will notify the member of his or her right to file a grievance. We will acknowledge a grievance in writing within five business days of its receipt and resolve it within 30 calendar days of its receipt. If we are unable to resolve the grievance within that time, we will send written notification before the 30-day period has expired that more time is needed, the reason more time is needed, and the expected date it will be resolved.

The member or the member’s authorized representative has the right to appear in person before the appeal and grievance committee to present written or oral information. We will notify the member in writing of the time and place of the meeting at least seven calendar days before the meeting. After a member’s grievance is reviewed, the member will receive a written notification of the committee’s decision, along with the titles of the people on the appeals and grievance committee.

**If a member’s grievance requires immediate action**

**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 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 us as soon as possible. We will resolve the expedited grievance within 72 hours of its receipt, unless more information is needed. If more information is needed, we 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 we do not consider urgent situations.

**If a member disagrees with our decision**

If a member’s grievance is denied, in whole or in part, we will send the member a notice that may state:
- The basis for the decision, including information the member needs 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 description of available external review processes
- Any information the member needs to perfect the claim or issue
- A statement that the member may request reasonable access to and copies of all documents, records and other information relevant to the appeal, which we will provide free of charge

If we fail to strictly adhere to all the procedures in this section, the member will be deemed to have followed these procedures. The member may, at the member’s expense, have legal representation at any stage of these grievance procedures. These grievance procedures are the only means through which an adverse benefit determination may be appealed. The member may resolve the problem by taking the steps outlined above. The member may also contact the OFFICE OF THE COMMISSIONER OF INSURANCE (OCI), a state agency that enforces Wisconsin’s insurance laws, and file a complaint. You can contact OCI by writing to:

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

You also may call 1-800-236-8517 outside of Madison or 608-266-0103 in Madison to request a complaint form. You also may email OCI at complaints@ociwi.state.us.

**External review program**

If Security Health Plan denies a member’s coverage, the member or the member’s authorized representative may have the right to request an independent external review of that decision. The member may obtain the contact information for the current certified independent review organization by calling Security Health Plan at 1-800-472-2363 or 715-221-9555.

If a member would like an independent review, a request must be submitted within four months of the member’s receipt of notice of the appeal and grievance committee decision. The independent review organization will make its decision within 30 days of its receipt of all information it has requested. If this organization decides to overturn our decision, we will provide coverage or payment for the member’s health care item or service.
SECTION VII – HOW WE PROTECT YOUR PRIVACY

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 is only a summary of Security Health Plan’s Notice of Privacy Practices. The full notice describes additional rights and may be accessed from the Security Health Plan website, www.securityhealth.org, or by calling Security Health Plan Customer Service at 1-800-472-2363.

Security Health Plan takes protecting the privacy of our members’ information very seriously. Security Health Plan complies with all applicable federal and state laws governing the privacy of our members’ health information, such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Security Health Plan has implemented administrative, technical and physical safeguards to secure protected health information. These safeguards include privacy policies and procedures, electronic “firewalls,” and limiting access to health information. Security Health Plan also has a privacy officer and a Privacy Committee in place to ensure its privacy policies are enforced and to enhance our privacy practices through routine reviews and updates.

In certain circumstances, Security Health Plan is required by law to obtain a member’s authorization before disclosing health information. When it is necessary to obtain authorization for the disclosure of health information or authorization of care and treatment, Security Health Plan will obtain authorization from the member (age 18 or older in most circumstances), parent, legal guardian, or other individual with the appropriate legal authority to make decisions on behalf of the member. We will disclose a member’s health information only with the member’s written authorization, unless otherwise permitted or required by law. Refer to the full Notice of Privacy Practices for a discussion of disclosures that do not require member authorization. Security Health Plan reserves the right to decide whether information should be disclosed to a legal guardian, lawful spouse, significant other, or other person/entity on a case-by-case basis.

With limited exceptions, Security Health Plan will provide members with access to their own claims, membership, or other records and information in a timely manner upon request.

Security Health Plan may share certain health information with third parties such as a member’s employer, a health care provider, or a regulatory agency. Security Health Plan at times enters business relationships with third parties that require the sharing of health information, in which case Security Health Plan obtains a written agreement before sharing any information. The written agreement requires the third party to comply with HIPAA and to have sufficient controls in place to safeguard health information. Member-identifiable information is shared with employer groups only in accordance with applicable privacy laws. With member authorization, notice of completion of a health and wellness promotion program (for example, a health-risk assessment) may be provided to the employer. Otherwise, only aggregate data may be shared with employers with respect to health-and-wellness promotion programs. Security Health Plan does not sell your health information to third parties. Security Health Plan employees are required to protect health information in any form (electronic and hardcopy) and maintain the confidentiality of such information. Security Health Plan has policies and procedures – computer passwords, for example – to limit employees’ access to members’ information to only that information needed to do their job (a need-to-know basis). Employees will use or disclose only the amount of information necessary to complete their duties. Security Health Plan employees sign a confidentiality statement annually and are subject to disciplinary action, up to and
SECTION VIII – DEFINITIONS

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, including resulting from the application of any utilization review
- A failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental and/or investigational, inappropriate or 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 under President Barack Obama in 2010 that targets medical consumer protections, new health coverage options, improved patient care and lower medical costs.

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

American Health Benefits 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.
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.

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 – An advanced-practice registered nurse who has specialized education and training in nursing and midwifery. Certified nurse midwives function as primary care providers for women and most often provide medical care for relatively healthy women, whose births are considered uncomplicated and not “high risk,” as well as their newborn children. Certified nurse midwives are required to possess a minimum of a graduate degree such as a Master of Science in nursing or post-master’s certificate. They are able to prescribe some medications, treatments, medical devices, therapeutic and diagnostic measures. Most certified nurse midwives provide medical care to women from puberty through menopause, including care for their newborn (neonatology), antepartum, intrapartum, postpartum and nonsurgical gynecological care.

Child/children – Natural children, stepchildren, legally adopted children, 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).

Child subscriber – The youngest covered person under a policy that does not cover any adults.

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

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.

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 occurs is considered one confinement.

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

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

**Custodial care** – Services given to a member if:
- The member does not require the technical skills of a registered nurse at all times
- The member needs assistance for activities of daily living including, but not limited to, dressing, bathing, eating, walking, taking medications or 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.

**Deductible** – The amount a member is required to pay in a benefit year before benefits are payable by Security Health Plan under the policy. Members 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, domestic partner and/or child.

**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
- Can withstand repeated use
- Is not disposable
- Is 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 woman, serious jeopardy to the health of the woman or her 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 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 we determine:
- Has not been approved by the appropriate governmental agency, such as but not limited to the Food and Drug Administration for the purpose it is being used for, which includes the member’s medical condition, is not demonstrated to be as beneficial as established alternatives
- Fails to demonstrate the procedure, treatment, supply, device or drug is safe and effective for the patient’s medical condition
- 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, outgoing clinical trials.

**Note:** A treatment, procedure, supply, device or drug may be considered experimental or investigational even if the health care provider has performed, prescribed, recommended, ordered or approved it, or if it is the only available procedure or treatment for the condition.

**Follow-up care** – Medically necessary care provided by a network health care provider or approved non-network health care provider specifically and directly related to, and provided within 120 days after receipt of, emergency/urgent care, or within 120 days after medical services for an injury, surgery or acute illness.

**Formulary** – A list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration (FDA). The formulary has been developed and reviewed by a committee of physicians, pharmacists and other health care professionals and is subject to periodic review and modification. The formulary applicable to each member’s plan is available upon request or on our website at www.securityhealth.org/formulary.

**Full-time student and full-time student status** – A covered dependent child in a regular full-time student 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. Full-time student status generally requires the student take 12 or more credits per semester. If outpatient services are recommended in the clinical assessment, no more than five visits to a non-network health care provider outpatient treatment facility or other health care provider will be covered. All non-network outpatient treatment facilities or health care providers must be in Wisconsin and reasonable proximity to the student’s school.

**Grievance** – Any dissatisfaction, written by or on behalf of a member, regarding an insurer that affects a health benefit plan or administration of a health benefit plan. Grievances can include 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.

**Health care provider** – Doctors, hospitals, clinics and any other person, institute or other entity licensed, certified or otherwise authorized to provide health care services within the scope of their license.

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

**HMO** – Also called a health maintenance organization. A health insurance plan that provides medical coverage within a network of participating health care 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 and prior approved by Security Health Plan.
Inpatient certification – A member must have his or her hospital call Security Health Plan before a planned in-patient hospital stay. The hospital will report how many days it expects the member to stay. Security Health Plan will then grant, or pre-certify, the member’s hospital stay for a certain number of those days. Security Health Plan might pre-certify the stay for fewer days than the hospital expects the member to stay. The member’s hospital then must prove that the additional days are medically necessary for the member to receive coverage for those days.

Inpatient rehabilitation facility - A hospital (or a special unit of a hospital that is designated as an inpatient rehabilitation facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

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 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, and restorative and activity programs. These services must be provided under professional direction and medical supervision as needed.

Maintenance/supportive care – Services provided to a member after the acute phase of an illness or injury has passed and maximum therapeutic benefit has occurred. Supportive care is services provided to a member whose recovery has plateaued, slowed or ceased entirely, and only minimal rehabilitative gains can be demonstrated with continued care. Security Health Plan determines what constitutes maintenance/supportive care after reviewing the member’s case history and a treatment plan submitted by a health care provider.
Individually Policy

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

Medically necessary – Medically necessary care involves treatments, services or supplies provided by a hospital or health care provider that are required to identify or treat a member’s illness or injury and which, as determined by Security Health Plan medical directors, are:

• Consistent with the member’s illness or injury
• In accordance with generally accepted standards of medical practice
• Not solely for the convenience of a member, hospital or other health care provider
• The most appropriate level of service that can be safely provided to the member in the most cost-effective manner

Note: “Generally accepted standards of medical practice” specifically refers to standards that are based on moderate or high-quality scientific evidence published in peer-reviewed medical literature.

• Psychological reactions to appearance or fear of disease do not constitute a basis for medical/surgical necessity, other than for behavioral health services
• Cosmetic services or plastic surgery are not a benefit unless they represent a functional medical necessity

If there are two or more medically necessary services that may be provided for the illness, injury or medical condition, Security Health Plan will provide benefits based on the most cost-effective service.

Hospital inpatient services, which are medically necessary, include only those services that satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in the physician’s office, the outpatient department of a hospital, or in another lesser facility without adversely affecting the patient’s condition or the quality of medical care rendered. Inpatient services not medically necessary include hospitalization:

• For diagnostic studies that could have been provided on an outpatient basis
• For medical observation or evaluation
• For personal comfort
• In a pain-management center to treat or cure chronic pain
• For inpatient rehabilitation that can be provided on an outpatient basis

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

Medical services – Services 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
- The most appropriate item which can be safely provided to the member and accomplish the desired end result in the most economical manner
- Prescribed by a physician. The item’s primary function must not be for the member’s comfort or convenience.

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 [including substance abuse, alcoholism, or drug abuse], as listed in the latest edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV) or the International Classification of Disease.

Network health care provider – A physician, practitioner, qualified treatment facility, pharmacy, hospital, behavioral health care hospital, clinic or other health care provider, who has a health care provider contract with Security Health Plan to provide medical treatment, services or supplies for Security Health Plan members.

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

New drug – A prescription drug or new dosage form, which may include a new formulation or combination of two or more prescription drugs or a combination of a prescription drug and over-the-counter drug, which has not previously been approved by the FDA.
- New drugs are not routinely covered for six months after FDA approval and commercial availability to allow Security Health Plan time to evaluate benefits, risks, coverage considerations and formulary status
- Health care providers may appeal to Security Health Plan for an exception review during this six-month period. Security Health Plan reserves the right to exclude products from coverage if, in its determination, alternatives are available

Non-network health care provider – Health care providers who do not have a contract with Security Health Plan.

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.

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

Physical illness – A change in a function, structure or system of the human body which 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 medical director 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.

Policy – The entire agreement issued to the individual or family that includes all of the following (if applicable):
- This document
- Schedule of Benefits
Individual Policy

• Riders
• Amendments
• The member’s application
• Any supplemental applications

Policyholder – The person who carries the insurance policy.

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

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

Primary care provider – A physician, nurse practitioner or physician’s assistant in adolescent medicine, family practice, internal medicine, general practice or pediatrics who a member sees to coordinate his or her health care.

Prior authorization – An agreement from Security Health Plan to provide coverage for medical services or equipment, before the member receives the services or equipment. A health care provider may contact Security Health Plan to determine whether a prior authorization is required for a member’s service or medical equipment by calling Customer Service at 1-800-472-2363. All of the following criteria for prior authorization must be met:
• The services are not available from any network health care provider
• The services are a covered benefit under the member’s coverage
• The services are medically necessary and appropriate

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

Professional services – Services directly provided to a member by a physician to treat a member’s illness or injury. Services may be provided by a certified registered nurse anesthetist, registered or licensed practical nurse, laboratory/X-ray technician or physician assistant.

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

Residential treatment facility – A facility that provides a program of effective substance-abuse 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 and approved by the substance-use disorder designee
• 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.

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.

Security Health Plan of Wisconsin, Inc. or Security Health Plan – A service insurance corporation with its principal office in Marshfield, Wisconsin, organized and existing under Chapter 613 of the laws of Wisconsin.

Service area – The geographic area Security Health Plan serves and in which members live.

Services – Hospital, professional, surgical, maternity, medical or any other service provided by a health care provider. Services include 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 to ensure the safety of the patient and to achieve the medically desired result.

Sound natural teeth – Teeth that:
  • Are organic and formed by the natural development of the human body
  • Are not manufactured
  • Have not become extensively restored
  • Have not become extensively decayed or involved in periodontal disease
  • Are not more susceptible to injury than whole natural teeth

Substance-abuse services – Treatment for alcoholism and drug abuse.

Substance-use disorder designee – The organization or individual, designated by Security Health Plan, who provides or arranges mental health services and substance use disorder services for which benefits are available.

Treatment – Management and care provided by a physician or other health care provider for the diagnosis, remedy and therapy, or the combination thereof, of an illness or injury, as determined by Security Health Plan.

Unproven services – Services including medications that have not been shown to be effective in treating a specific medical condition through well-conducted trials or cohort studies.

Urgent care – Care a member needs sooner than a routine doctor’s visit for unforeseen needs.
SecurityHealth Plan
Promises kept, plain and simple.

1515 N Saint Joseph Avenue
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7 a.m. to 5:30 p.m. Monday through Friday
www.securityhealth.org