	Item	District Response	Answer Format
	Basic Information		
1.	LEA code	5603	4 digit number; if unknown, car
2.	School district name	School District of Shell Lake	Text
3.	Number of plans offered	One	Drop-down menu (choose 1)
4.	Plan structure	Fully insured	Drop-down menu (choose 1)
5.	Plan chosen by the majority of employees eligible for coverage		Text
6.	Type of plan	Health Maintenance Organization (HMO)	Drop-down menu (choose 1)
7.	Percent of staff eligible for insurance and enrolled in the plan	0.75	Percentage (2 decimal points; i.
8.	Eligibility	Family (Employee, Spouse, All Dependents)	Drop-down menu (choose mult
9.	Coverage	Medical	Drop-down menu (choose mult
	Single Plan Information		
		Medical	
10.	Total monthly premium	$ 727.86	Dollars
11.	Employer contribution to premium	$ 630.32	Dollars
12.	Employee contribution to premium	$ 97.54	Dollars
13.	If HSA, total employer contribution	$ 500.00	Dollars
14.	Deductible	$ 3,000.00	Dollars
15.	Employer share of deductible	$ -	Dollars
16.	Out of pocket maximum	$ 3,000.00	Dollars
	Family Plan Information		
17.	Total monthly premium	$ 1,644.96	Dollars
18.	Employer contribution to premium	$ 1,424.53	Dollars
19.	Employee contribution to premium	$ 220.43	Dollars
20.	If HSA, total employer contribution	$ 1,000.00	Dollars
21.	Deductible	3000/6000	Dollars
22.	Employer share of deductible	$ -	Dollars
23.	Out of pocket maximum	3000/6000	Dollars
	Other Plan Information		
24.	Describe any premium differential		Text
25.	Describe any in-network co-pays		Text

26.	Co-insurance percentage, if any	Percentage (2 decimal points; i
27.	Other information	Text

Schedule of Benefits - HMO Premier
Group - NORTHWEST COOP
Benefit Year: January 1st through December 31st
Effective Date: 07/01/2018

SecurityHealth Plan℠

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

This Schedule shows your specific cost-sharing, as well as any additional benefits, limitations or exclusions not shown in your Certificate. It also provides a very general summary of your benefits for certain types of services; **you will need to read it in conjunction with your Certificate for details about your coverage.** Benefits are calculated according to the benefit year shown above. **NOTE: All services must be received from affiliated providers, except as otherwise described in the Certificate.**

Your Responsibilities	
Deductible This plan is intended to qualify as a high deductible health plan that may be paired with a health savings account; however, you should check with your tax advisor for guidance on your particular situation.	$3,000 per individual $6,000 per family The family deductible can be met by any combination of members within a family. If one family member meets the individual deductible, the deductible is satisfied for his or her claims. The maximum deductible is equal to the family deductible.
Annual out-of-pocket (Deductible, coinsurance & copayments)	$4,000 per individual $8,000 per family The family annual out of pocket can be met by any combination of members within a family. If one family member meets the individual annual out of pocket, the annual out of pocket is satisfied for his or her claims. The maximum annual out of pocket is equal to the family annual out of pocket.
Dependent wrap coverage In addition to the benefits described in the Follow-up Care section of the Certificate, dependents living outside of the service area are provided benefits for covered services from non-affiliated providers.	Such coverage shall be provided at the in network level of benefits.

Your Benefits	
Ambulance services	Subject to deductible
Anesthesia services	Subject to deductible
Care my way (Marshfield Clinic Health System service)	Subject to deductible
Chiropractic services	Subject to deductible
Durable medical equipment and medical supplies (Including insulin pump and supplies)	Subject to deductible
Hearing examinations	Subject to deductible
Home health care	Subject to deductible (Limited to 40 visits per individual per calendar year)

Schedule of Benefits - HMO Premier
Group - NORTHWEST COOP
Benefit Year: January 1st through December 31st
Effective Date: 07/01/2019

SecurityHealth Plan

Your Benefits	
Hospice care	Subject to deductible
Hospital emergency room services	Subject to deductible
Hospital inpatient services (Including semi-private or special care room, operating room, ancillary services and supplies)	Subject to deductible
Hospital outpatient and surgical center services (Not including emergency room)	Subject to deductible
Maternity services	
• **Hospital services**	Subject to deductible
• **Physician services**	Subject to deductible
Mental health and substance abuse services	
• **Inpatient care**	Subject to deductible
• **Outpatient care**	Subject to deductible
• **Transitional care**	Subject to deductible
Office visits	Subject to deductible (Preventive exams covered at 100%)
Outpatient laboratory services	Subject to deductible
Outpatient radiology services	Subject to deductible
Outpatient therapy services	
• **Occupational therapy**	Subject to deductible
• **Physical therapy**	Subject to deductible
• **Speech therapy**	Subject to deductible
Physician services	
• **Hospital services**	Subject to deductible
• **Other services in an office**	Subject to deductible (Preventive immunizations covered at 100%)

Schedule of Benefits - HMO Premier
Group - NORTHWEST COOP
Benefit Year: January 1st through December 31st
Effective Date: 07/01/2019

SecurityHealth Plan℠

Your Benefits	
Preventive benefit Please refer to Security Health Plan's Preventive Service Guidelines at www.securityhealth.org/preventive for service frequency recommendations.	
• **Comprehensive physical examination** (complete physical) ~ Well-baby care ~ Well-child care ~ Adolescent well-care visits ~ Adult well-care visits ~ Screening for interpersonal and domestic violence ~ Counseling for sexually transmitted infections	Covered at 100%
• **Gynecological examination** (breast exam and pelvic exam)	1 per calendar year then subject to deductible
• **Digital prostate examination**	1 per calendar year then subject to deductible
• **Preventive hearing test**	1 per calendar year then subject to deductible
• **Mammogram to screen for breast cancer**	1 per calendar year then subject to deductible
• **Pap smear to screen for cervical cancer**	1 per calendar year then subject to deductible
• **Comprehensive preventive vision examination**	1 per calendar year then subject to deductible
• **Colonoscopy screening for colorectal cancer**	1 every two years then subject to deductible
• **Other screenings for colorectal cancer** ~ Sigmoidoscopy ~ Double contrast barium enema ~ Fecal occult blood testing	1 per calendar year then subject to deductible
• **Screening laboratory services** Including, but are not limited to: basic metabolic panel, BRCA (1 & 2) testing, breast cancer genetic testing, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), pediatric lead poisoning screening, prostate specific antigen (PSA), and urinalysis.	Each laboratory service covered at 1 per calendar year then subject to deductible
• **Bone mineral density (dexa scan) to screen for osteoporosis**	1 per calendar year then subject to deductible
• **Chlamydia screening**	1 per calendar year then subject to deductible
• **Ultrasound for screening of an abdominal aortic aneurysm**	1 per calendar year then subject to deductible
• **Breast feeding support and counseling**	Covered at 100%

Schedule of Benefits - HMO Premier
Group - NORTHWEST COOP
Benefit Year: January 1st through December 31st
Effective Date: 07/01/2019

SecurityHealth Plan

Your Benefits	
• **Immunizations and vaccinations** (including those needed for travel)	Covered at 100%
Skilled nursing facility	Subject to deductible (Limited to 30 days per individual per confinement)
Surgical services	Subject to deductible
Temporomandibular joint disorders or TMJ non-surgical treatment	Subject to deductible (Limited to 4 physical/occupational visits for diagnosis of TMJ per year)
Transplant services	Subject to deductible
Vision examinations	Subject to deductible

Pharmacy	
• 100% coverage for preventive prescription drugs (not subject to deductible). Please refer to the Preventive Medication List for a list of covered products. • Up to 30 days worth of prescription drugs constitutes a 1-month supply. For most maintenance prescription drugs you may receive up to a 90-day supply and if applicable, 3 copayments and/or coinsurance and/or deductible will be assessed. • Pharmacy mail service may supply maintenance prescription drugs in a 90-day supply and if applicable, 2 copayments and/or coinsurance and/or deductible will be assessed. • 100% coverage for smoking cessation products, limited to 180 days per year. • The use of a specialty pharmacy may be required for select prescription drugs, as indicated in the Formulary Guide.	Subject to deductible. After deductible, the following copayments and/or coinsurance apply to covered prescription drugs until the maximum out-of-pocket is met. $10 copayment per tier 1 prescription or refill. $30 copayment per tier 2 prescription or refill. $60 copayment per tier 3 prescription or refill. 25% coinsurance per TIER 4 prescription or refill (specialty prescription drugs). If the participant requests the brand name prescription drug where a generic is available, the participant must pay the applicable copayment/coinsurance plus the ancillary charge. The ancillary charge is the cost difference between the brand name prescription drug and the generic prescription drug. The ancillary charge will not count towards the prescription out-of-pocket limit.

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

Prior Authorization

The following services require you to obtain prior authorization before receiving the service. Your health care provider can start the prior authorization process by downloading a printable Prior Authorization Form at www.securityhealth.org/authorization or contact us at 1-800-548-1224.

Medical Services

- Abdominoplasty
- Air ambulance transport
- Amino Acid Formula
- Autologous Cultured Chondrocytes
- Clinical trials
- Cosmetic and reconstructive surgery
- Elective inpatient Admission including medical (acute and behavioral health) and surgical
- Enteral feeding
- Experimental or investigational services
- Fecal transplant
- Femoro-acetabular surgery for hip impingement syndrome
- Gender reassignment
- Genetic testing
- Home health including but not limited to skilled nursing, physical therapy, occupational therapy, speech therapy
- Hospice
- Infuse bone graft
- Lung volume reduction surgery
- Non-affiliate provider request
- Non-emergent ambulance transport
- Office procedure with site of service request other than in an office setting
- Outpatient procedure with site of service request as inpatient setting
- Outpatient therapy treatment (occupational therapy, physical therapy, speech therapy)
- Second opinion
- Skin substitutes
- Spinal cord stimulation
- Swing bed admission
- Transplants
- TMJ
- Elective outpatient procedures such as, but not limited to: carpal tunnel surgery, knee arthroscopy, back surgeries at all levels

This list of medical services is not all inclusive. The most up-to-date medical services list requiring prior authorizations can be found on our website at www.securityhealth.org/authorization. You can also call our Customer Service Department at 1-844-293-9624 to find out what medical services require prior authorization.

Durable Medical Equipment

For most durable medical equipment (DME), you will need to work with your provider to receive prior authorization from Northwood at 1-866-532-1344.

High-end imaging / Radiation oncology

For all high-end imaging and radiation oncology services, you will need to work with your provider to receive prior authorization from eviCore healthcare.

For high-end imaging
- www.medsolutionsonline.com
- Phone 1-888-693-3211
- Fax an eviCore request form (available online) to 1-888-693-3210

For radiation oncology
- www.carecorenational.com
- Phone 1-888-444-6185

Skilled Nursing Facility Services

For the skilled nursing facility services listed, you will need to work with your provider to notify NaviHealth at 1-855-512-7002 (Fax 1-855-847-7243).

- Acute rehabilitation admission
- Long term acute care admission
- Skilled nursing facilities admission

Medical Benefit Drugs

Medical benefit drugs may require prior authorization. The most up-to-date medical benefit drug list can be found on our website at www.securityhealth.org/SpecialtyRx. Medical benefit drugs may be added or removed from this list quarterly on a calendar year basis. You can also call our Customer Service Department at 1-844-293-9624 to find out what medical benefit drugs require prior authorization. For medical benefit drug prior authorization, you will need to work with your provider to notify Magellan at 1-800-424-8243.

Home Infusions

Home infusion drugs may require prior authorization. The most up to date Home Infusion drug list can be found on our website at www.securityhealth.org/homeinfusion. Home infusion drugs may be added or removed from this list quarterly on a calendar year basis. You can also call our Customer Service Department at 1-844-293-9624 to find out what medical benefit drugs require prior authorization for home infusion.

Statement of Nondiscrimination

Security Health Plan of WI, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status.

Limited English Proficiency Services
ENGLISH: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-844-293-9624 (TTY:711). ATENCION: Si habla espanol, tiene a su disposicion servicios gratuitos de asistencia linguistica. Llame al 1-800-472-2363 (TTY: 711). LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-472-2363 (TTY: 711).

SecurityHealth Plan℠ NORTHWEST COOP

Coverage Period:
07/01/2019 - 06/30/2020

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family **Plan Type:** HMO Premier

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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$3,000 Indiv/$6,000 Family	Generally, you must pay all the costs from providers up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without cost sharing and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	$4,000 Indiv/$8,000 Family	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Premiums, balanced-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See www.securityhealth.org/directory or call 1-800-472-2363 for a list of network providers.	This plan uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (balance billing). Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	Yes.	This **plan** will pay some or all of the costs to see a **specialist** for covered services but only if you have a **referral** before you see the **specialist**.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations & Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	Not covered	None
	Specialist visit	0% coinsurance	Not covered	Please refer to your policy plan documents for more specific information.
	Preventive care/screening /immunization	Covered at 100%	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not covered	Please refer to your policy plan documents for more specific information.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.securityhealth.org/prescription-tools	Generic drugs (Tier 1)	$10 copayment	Not covered	Provider means pharmacy for purposes of this section. Most pharmacies nationwide are included in the provider network (more than 50,000 pharmacies). You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have prior authorization requirements. You may be required to use a lower-cost drug(s) prior to coverage being available for certain prescribed drugs.
	Preferred brand drugs (Tier 2)	$30 copayment	Not covered	
	Non-preferred brand drugs (Tier 3)	$60 copayment	Not covered	
	Specialty drugs (Tier 4)	25% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not covered	None
	Physician/surgeon fees	0% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations & Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Cost sharing may apply for services performed in the ER (such as labs, X-rays).
	Emergency medical transportation	0% coinsurance	0% coinsurance	None
	Urgent care	0% coinsurance	0% coinsurance	When you're in the service area, benefits are payable for urgent care services only when provided by an affiliated provider. Cost sharing may apply for services performed in the UC (such as labs, X-rays).
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	None
	Physician/surgeon fee	0% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	Not covered	Please refer to your policy plan documents for more specific information.
	Inpatient services	0% coinsurance	Not covered	
If you are pregnant	Office visits	0% coinsurance	Not covered	None
	Childbirth/delivery professional services	0% coinsurance	Not covered	Depending on the type of services cost sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	0% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not covered	Please refer to your policy plan documents for more specific information.
	Rehabilitation services	0% coinsurance	Not covered	
	Habilitation services	0% coinsurance	Not covered	
	Skilled nursing care	0% coinsurance	Not covered	
	Durable medical equipment	0% coinsurance	Not covered	
	Hospice services	0% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations & Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	0% coinsurance	Not covered	Please refer to your policy plan documents for more specific information.
	Children's glasses	Not covered	Not covered	Glasses are generally not covered; please refer to your plan documents for specifics.
	Children's dental check-up	Not covered	Not covered	This policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture (if prescribed by a physician for rehabilitation purposes)
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Hearing aids
- Routine eye care (Adult)

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

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

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standard? Yes

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

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

About these Coverage Examples:

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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,100**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Addendum

Notice of Nondiscrimination:

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

Security Health Plan:

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

If you need these services, contact Customer Service. If you believe that Security Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Security Health Plan
Attn: Grievances
1515 North Saint Joseph Avenue
Marshfield, WI 54449-8000

Phone: 715-221-9596 (TTY: 711) Fax: 715-221-9424
Email: shp.appeals.grievance@securityhealth.org

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

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

Phone: 1–800–368–1019 or 800–537–7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Access Services:

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

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

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

Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-472-2363 (TTY: 711).

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

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

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

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

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

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

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

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

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

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

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

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

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