

SecurityHealth PlanSM

Promises kept, plain and simple.[®]

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711

www.securityhealth.org

Welcome to Security Health Plan!

We are honored to partner with your employer to offer health benefits that can help you realize your best health. Inside this packet you will find all the information you need to enroll.

Our Employer Coverage Customer Guide helps you understand the value of being a Security Health plan member, and identifies the major health systems that are part of your network.

You can find which network your employer is offering by asking your human resources representative or looking in the top left corner of your Schedule of Benefits (circled here).

Schedule of Benefits - YOUR NETWORK NAME
Group ##### - YOUR EMPLOYER'S NAME
Benefit Year: Month/Year through Month/Year
Effective Date: MM/DD/YYYY

SecurityHealth PlanSM

Please read through the information carefully before you enroll. If you have questions about your health insurance benefits, please contact your human resources department or benefit consultant and they can help you get in touch with your dedicated Security Health Plan account manager.

Sincerely,

Your Security Health Plan Account Manager

2026

Employee Coverage Customer Guide

Large employer coverage



SecurityHealth Plan

Promises kept, plain and simple.®

When *you* have Security, you get so much more than health insurance.



What do you expect from high-quality health

insurance? With Security Health Plan, you get what you expect: clear benefit statements, accurate and on-time claims payments, and friendly and knowledgeable customer service. As a member you'll have access to our secure member portal and app, *My Security Health Plan*, where you'll find convenient, 24/7

access to information about your health benefits. Being a member of Security Health Plan comes with so much more than just health care coverage. We have outlined some of the extra benefits you get with your plan in this guide.

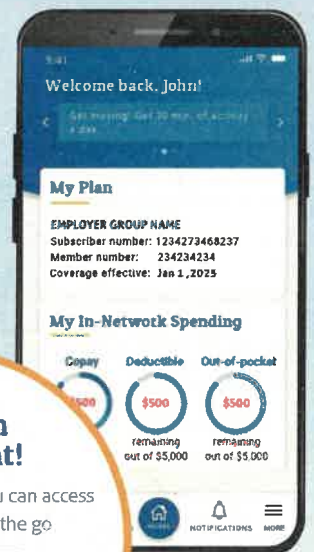
My Security Health Plan secure online access

Enjoy fast, easy and secure online access to your health plan information. Some things you can do with *My Security Health Plan* include:

- Live chat with Customer Service
- Check deductibles
- Track claims
- Find an in-network provider
- Find a pharmacy
- View and request ID cards
- Place a quarterly OTC order
- Take a WebMD health assessment
- Enroll in wellness support programs
- Send a secure message
- Request a call from a nurse
- Read plan documents
- Start a Care My Way® virtual visit
- Estimate the cost of medical services



Watch a short video about many of the features of *My Security Health Plan* at www.securityhealth.org/MyAccount



There's an app for that!

Download our app so you can access your health plan on the go



Preventive care

Even if you feel healthy, it's important to receive regular preventive screenings. Visiting your primary care provider for routine preventive care can lower your risk for illness, disease and other health problems. Security Health Plan continuously works to provide high-quality health care coverage and benefits that are aligned with evidence-based medicine guidance from the U.S. Preventive Services Task Force. Visit www.securityhealth.org/preventive for more information about frequency of preventive services.



Covered preventive services	Recommended for:
Preventive exams (comprehensive physical examinations)	Everyone
Blood pressure screening	Adults
Breast cancer screening (mammogram, includes 2D and 3D imaging)	Adults
Breastfeeding support, supplies and counseling	New moms
Cervical cancer screening (pap smear)	Adults age 21-65
Cholesterol screening	Adults age 40-75
Colorectal cancer screening	Adults age 45 and older
Depression screening	Adults and adolescents age 12-18
Diabetes Type 2 screening	Adults age 35-70 and body mass index 23+
Immunizations and vaccinations (includes those required for travel)	Everyone
Prostate cancer screening (prostate specific antigen test - PSA)	Adults age 55-69
Nicotine cessation	Members who want to quit using nicotine
Well child examinations	Children under 18

Over-the-counter benefit

You are eligible for a \$30 quarterly credit to purchase select over-the-counter (OTC) products through our catalog and have them delivered to your home at no charge. Learn more at www.securityhealth.org/OTC. Please check with your employer to see if this benefit is part of your plan.



Care My Way® virtual visits

Feeling ill, but not sure if you need to schedule a doctor appointment? Does your loved one have a fever and you don't know if you should head to Urgent Care? Use Care My Way and have access to reliable health information without the burden of spending time and money on a regular office visit.

If you describe symptoms related to a common health condition, the nurse practitioner will verify your symptoms and, if needed, call a prescription into the network pharmacy of your choice – saving you time and hassle.





Discounts on fitness center memberships and wellness support

Your membership with Security Health Plan gives you access to Husk; premier fitness, weight loss and wellness brands at a discount. You can also take advantage of educational materials, resources and tools to engage and motivate you. Learn more at marketplace.huskwellness.com.

You will enjoy discounts on:

- Fitness tracking devices
- Nutrition and meal plans
- Fitness center memberships or online fitness classes

Personalized health support



→ Home infusion care

You can get infusion therapy in the comfort of your home. Home infusion offers a convenient alternative to extended stays at hospitals, skilled nursing facilities or infusion clinics for medications, nutrition and hydration requiring steady intravenous administration over time. Learn more at www.securityhealth.org/infusion.

→ Pain management support

It is important you have alternative ways to manage pain. Trigger point dry needling is a safe and cost-effective treatment available as an alternative to pain medications or other more invasive pain management services. Alternative treatments like dry needling can also reduce reliance on expensive and dangerous prescription counterparts, like opioids.

→ Free medication review

With just a 15-minute phone call, one of our pharmacists can do a free Medication Therapy Management review of your medications, answer your questions about your prescriptions and over-the-counter drugs and may be able to find lower-cost alternatives to your prescriptions (if appropriate). Our trained pharmacists will make sure you're taking the right medication, the right dose and at the right time.

Wellness services



→ Our **online health assessment** is designed to help you understand your health. In about 10 minutes you'll receive a personalized plan to help you reach your best self. Print a copy of your results to discuss with your provider at your annual preventive exam.

→ No-cost **annual preventive exam** including a biometric screening with a primary care provider helps you detect potential health problems.

→ **Over-the-phone personalized health coaching** will connect you with a motivating and understanding professional to help you with losing weight, quitting nicotine, increasing physical activity, healthy eating, managing stress and more.

Care management and you

Care management involves you, your family, your doctor and your health plan. We all work together to make sure you get the high-quality health care you need.



Care management is a free service to you. Our care managers can:

- Help you better understand your medical needs
- Assist you in managing your medications
- Explore choices for your health care
- Give you confidence to make your health care decisions
- Help you recover fully and avoid having to go back into the hospital
- Connect you with health resources in your community

Learn more at www.securityhealth.org/manageyourcare.

Local, award-winning customer service

Worried or confused about health insurance? Do you have a question about how your health benefits cover a specific service?

A world-class* team of local representatives is here to help you with any questions you have: big or small. You will get the answers you need when you contact us – via phone, email, or online chat through *My Security Health Plan* online access. We always strive to resolve your questions on your first call. And if we don't know the answer, we'll find it and call you back.



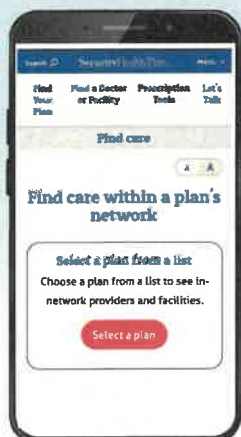
Customer Service • 1-800-472-2363 • shpcsweb@securityhealth.org



Use the ***My Security Health Plan*** member portal or app to send a secure message or get in touch through live chat!

**Security Health Plan has been recognized by Service Quality Measurement (SQM), a leading North American research firm that specializes in customer service improvement, with the world-class customer experience certification each year since 2016.*

Find a provider or facility with our online tool.



1. Visit www.securityhealth.org/directory.
2. Click "Select a plan"
3. Choose "Employer" and then "Other employer coverage" from the second drop-down menu.
4. Select the plan name you are interested in.
5. Enter your ZIP code and any other required information and click "Search" to view results.



Great coverage and employee perks.

Security Health Plan offers multiple plan types and network options customized to meet a wide variety of member needs.

Your employer may offer one or more of these plans. Review the materials in your enrollment packet to determine which plans are being offered.



You can find your plan name and network on the top left corner of your Schedule of Benefits.

→ **SimplyOne**

HMO/POS – SimplyOne gives you access to the one provider system that simplifies your path to health care – Marshfield Clinic.

SimplyOne perks

- Lower copays for prescription drugs filled at a Marshfield Clinic pharmacy
- Access to Sanford Health providers at in-network rates.

→ **Enrich**

HMO/POS – Enrich offers access to powerful, local provider systems plus many specialty care providers.

- Marshfield Clinic
- Sanford Health
- UnityPoint Health – Meriter
- UW Health

Enrich perk

- Lower copays for prescription drugs filled at a Marshfield Clinic pharmacy

→ **Inspire**

HMO – Inspire is a plan option that gives you in-network access to three key health systems, with the lowest out-of-pocket costs.

- Marshfield Clinic
- Sanford Health
- Mayo Clinic Health System

➔ Premier

HMO/POS – Premier delivers great value for your health care dollar, giving you access to a powerful network of providers when and where you need it.

- Marshfield Clinic
- Sanford Health
- Aspirus
- Essentia Health
- Hospital Sisters Health System (HSHS) hospitals – Wisconsin locations
- Mayo Clinic Health System
- OakLeaf Medical Network (select providers)
- Prevea Health – Wisconsin locations
- Aspirus St. Luke's
- Tamarack Health
- ThedaCare
- UnityPoint Health – Meriter
- UW Health

➔ Explore

HMO/POS – Explore gives you the power of choice, regionally and nationwide, between an incredibly diverse, high-quality network of doctors, clinics and hospitals.

- Marshfield Clinic
- Sanford Health
- Aetna - Outside of Wisconsin
- Aspirus
- Essentia Health
- Hospital Sisters Health System (HSHS) hospitals – Wisconsin locations
- Mayo Clinic Health System
- OakLeaf Medical Network (select providers)
- Prevea Health – Wisconsin locations
- Aspirus St. Luke's
- ThedaCare
- UnityPoint Health – Meriter
- UW Health
- First Health Network - Wisconsin locations



Logos shown are major provider systems – view the lists on these pages or our online directory for the coverage you are considering.



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, exclude or treat people differently on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation in the administration of the plan, including enrollment and benefit determinations.

Security Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages
- If you need these services, contact Customer Service at 1-800-472-2363 (TTY 711).

If you believe that Security Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation, you can file a grievance with a Section 504 Coordinator at:

Attn: Section 504 Coordinator
2301 E. 60th Street
Sioux Falls, SD 57103

Phone: 877-473-0911 (TTY 711) Fax: 605-312-9886
Email: shp.appeals.grievance@securityhealth.or

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, a Security Health Plan Section 504 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201

Phone: 1-800-368-1019 or 800-537-7697 (TDD)
More information is available at <http://www.hhs.gov/ocr/index.html>.



Language assistance services

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

Español (Spanish)

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

Hmoob (Hmong)

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

繁體中文 (Chinese)

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

Deutsch (German)

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

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-472-2363 (رقم هاتف الصم والبكم 117).

Русский (Russian)

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

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-472-2363 (TTY 711) 번으로 전화해 주십시오.

Tiếng Việt (Vietnamese)

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

Deitsch (Pennsylvania Dutch)

Wann du Deitsch schwetztscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: 1-800-472-2363 (TTY 711)

ພາສາລາວ (Lao)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-472-2363 (TTY 711).

Français (French)

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

Polski (Polish)

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

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-472-2363 (TTY 711) पर कॉल करें।

Shqip (Albanian)

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

Tagalog (Filipino)

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

မြန်မာ (Burmese)

သတိပြုရန်- သင်အင်္ဂလိပ်စကားပြောဆိုပါက၊ ဘာသာစကားအကူအညီပေးရေးဝန်ဆောင်မှုများသည် သင့်အား အခမဲ့ရရှိနိုင်ပါသည်။ 1-800-472-2363 (TTY 711) ကိုခေါ်ဆိုပါ။

Soomaali (Somalia)

ATENSYON: Haddii aad ku hadasho afka Soomaaliha, adeegyada caawimada luqadda waxaa lagu heli karaa iyagoo bilaash ah. Wac 1-800-472-2363 (TTY 711).

If you require materials in large print, please call 1-800-472-2363 (TTY 711).



Supporting your local community

Security Health Plan is a not-for-profit health insurance company based right here in Wisconsin.

We are invested in your well-being and in your community's well-being. We are committed to not only improving your health, but also to improving health throughout Wisconsin. We are constantly looking for opportunities to serve and give back to those communities in which we all live, work and play.



About Security Health Plan

Security Health Plan of Wisconsin, Inc., together with Sanford Health Plan, is helping 423,000 members in Wisconsin and throughout the Midwest achieve their best health. Security, a not-for-profit health plan, has served Wisconsin since 1971 with health insurance coverage for employees of large and small businesses, individuals and families. Additionally, Insite by Security Health Plan offers full-service medical third-party administration in Minnesota, Michigan, Wisconsin and Indiana.

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1-800-472-2363
715-221-9555
TTY 711
Fax 715-221-9500

shpcsweb@securityhealth.org
www.securityhealth.org



Coverage for preventive medications

Learn about preventive medications covered at 100% under your employer plan

Taking preventive medications prescribed by your doctor can help you manage any health conditions you have and avoid serious illness. That's why Security Health Plan's pharmacy benefit on high-deductible health plans may include special coverage for preventive medications. These medications may include drugs to reduce the risk of blood clots or medications to manage blood sugar. The medications identified as preventive are maintained by Optum Rx Clinical Services and adopted by Security Health Plan.



Save on preventive medications

Your employer health plan covers certain preventive medications at 100%, meaning no copay or cost to you. Preventive medications covered at 100% are listed in Security Health Plan's Formulary Guide for large employers.



To see if your medications are eligible:

- Visit www.securityhealth.org/prescription-tools
- Select "Employer search" under For members with employer coverage
- Select "Covered drugs" under Large employer
- Click "Comprehensive formulary" to view a list of covered medications
- Search for your medication name within the formulary document

If your medication is preventive, a PV will be listed in the right column under Limits/Required.

Drug Name	Drug tier	Limits/Require
SILENOR	3	BP; QL
SODIUM OXYBATE SOLUTION 500 MG/ML ORAL	4	PA; SP; QL
SUNOSI TABLET 150 MG ORAL	2	PA; QL

Please note: The preventive buy-up option is an additional benefit that large employers may choose to offer their employees at an extra cost to the employer. Please refer to your plan documents for coverage information.

SecurityHealthPlanSM

Receiving *care* after hours...

Security has *you* covered!

When every minute counts, feel confident in where to go for your health care needs.

You have a minor burn



Start by calling Care My Way

Call 1-800-549-3174

An appointment coordinator will ask you about your health problem.

A nurse will advise you based on your responses and may:



Provide instructions for care at home.



Call a prescription to your preferred pharmacy.



Suggest you visit a health care provider.



Recommend you visit urgent care or the emergency department.

Care My Way®

You can receive care virtually using the Care My Way® app or by calling **1-800-549-3174**. Once you explain your symptoms, a trusted, experienced nurse practitioner provides a quick diagnosis and treatment plan for conditions that normally require an office visit. Care My Way nurse practitioners can even send prescriptions to the pharmacy of your choice. Services are available 24 hours a day, 7 days a week, in all 50 states.

Most members of Security Health Plan receive unlimited visits with Care My Way. For more information about the service, visit www.securityhealth.org/CareMyWay.

There's an app for that!



Download the Care My Way app for a virtual visit and care on the go.



Emergency department vs urgent care

Emergency department	Urgent care
In a medical emergency or in doubt, call 911. Emergency departments treat sudden, ongoing or severe illnesses, injuries, pain and other emergent symptoms, including but not limited to: • High fever • Eye injuries • Head injuries • Abdominal pain • Persistent chest pain • Blood in stool	You can receive care at an urgent care location or virtually using Care My Way for conditions such as: • Cold or flu • Joint or back pain • Eye irritation or pink eye • Allergies or bronchitis • Rashes, hives or infections

Care My Way® is available 7 days a week, including holidays.

Notice of Nondiscrimination

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Limited English Proficiency Language Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-472-2363 (TTY 711). **ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. 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).

If you require materials in large print, please call 1-800-472-2363 (TTY 711).

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1-800-472-2363 (TTY 711)
715-221-9199

shpcsweb@securityhealth.org

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Promises kept, plain and simple.®

**The right care,
right now.**

When to use:

- Care My Way®
- Urgent care
- Emergency care

Large (Existing) and Small (New/Existing) Employer (without medical questions) Employee Health Insurance Application

A signature within Section E and/or F is required to make the application valid. If you need additional space, use a separate sheet of paper and attach it to this application (sign and date the additional sheet).

A. Employer information

Employer name _____

Group number _____

Effective date (m/d/y) ____ / ____ / ____

B. Employee information *Fill out the entire application and include information for spouse and/or dependents seeking coverage.*

First name, middle initial and last name		Former last name (if applicable)		Marital status:	
				☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic partner	
Sex assigned at birth:	Social Security number	Date of birth (m/d/y)			
☐ Male ☐ Female					
Physical address (P.O. box not accepted)		City	State	ZIP	County
Mailing address ☐ Same as physical address		City	State	ZIP	County
Home phone number (area code)		Work phone number (area code)		Cell phone number (area code)	
Email address		Primary care provider/facility			

Work status and qualifying election:

- ☐ Actively working: Hire/rehire date (m/d/y) ____ / ____ / ____
 Date of change from part-time to full-time (m/d/y) ____ / ____ / ____ **OR** Return to work date (m/d/y) ____ / ____ / ____
☐ Retired date (m/d/y) ____ / ____ / ____

If you are enrolling due to a loss of coverage, submit proof of loss to your employer.

- ☐ COBRA or state continuation: Start date (m/d/y) ____ / ____ / ____ End date (m/d/y) ____ / ____ / ____
☐ Special enrollment (*documentation, qualifying event and event date required*) Date of event (m/d/y) ____ / ____ / ____
☐ Birth/adoption ☐ Marriage ☐ Permanent move ☐ Loss of coverage ☐ Individual coverage HRA

Race or ethnicity:

- ☐ White ☐ Black or African American ☐ Hispanic or Latino
☐ Asian ☐ Native American ☐ Alaska Native
☐ Native Hawaiian ☐ Pacific Islander
☐ Specify _____

What primary language is spoken in your home:

- ☐ English
☐ Specify _____

Coverage desired: ☐ Single ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family

WAIVING COVERAGE (*skip to Section F. Health coverage waiver*)

If married and only selecting coverage for yourself, complete Section F for your spouse/dependent.

C. Dependent information *List everyone enrolling in coverage (spouse, dependents)*

Name (First, MI, Last)	Birth date (m/d/y)	Sex assigned at birth	Social Security number	Relationship	Primary care practitioner name and facility
	__ / __ / __	☐ Male ☐ Female		☐ Spouse ☐ Domestic partner*	
	__ / __ / __	☐ Male ☐ Female		☐ Child/stepchild	
	__ / __ / __	☐ Male ☐ Female		☐ Child/stepchild	
	__ / __ / __	☐ Male ☐ Female		☐ Child/stepchild	
	__ / __ / __	☐ Male ☐ Female		☐ Child/stepchild	

* If allowed by your plan

Do any of the above family members live at a different address: ☐ Yes ☐ No

If yes, indicate name and address _____

D. Information regarding other health coverage and/or Medicare

1. If you, your spouse or your dependent child(ren) listed in this application have current coverage that will continue after your Security Health Plan coverage starts, complete the following table or submit a copy of your insurance card.

Subscriber of other health coverage and/or Medicare		DOB (m/d/y) ____/____/____
Insurance company	Group number	Policy number
Family members covered		Type of coverage:
		☐ Employer group health coverage
		☐ Drug coverage only
		☐ Individual health coverage

2. Are you or any of your family members eligible for Medicare: ☐ Yes ☐ No

If yes, complete the following or attach a copy of your Medicare card.

Name of person covered by Medicare _____ Medicare card number _____

Is Medicare eligibility due to: ☐ Over age 65 ☐ End-stage renal disease (ESRD) ☐ Total disability

Effective dates (m/d/y): Part A ____/____/____ Part B ____/____/____ Part C (Medicare Advantage) ____/____/____ Part D ____/____/____

E. Terms and conditions

- All statements and answers in this application are representations made by the applicant on his/her own behalf and for the other persons named in this application to induce the issuance of the contract(s) applied for.
- Subject to acceptance of this application by Security Health Plan of Wisconsin, Inc. it is understood and agreed that each participant consents to furnish Security Health Plan of Wisconsin, Inc., with all such medical and surgical reports, records and other information as requested to process claims. This might include signing a form for the release of information from hospitals, doctors and other health care providers to Security Health Plan of Wisconsin, Inc.
- Subject to the acceptance of this application by Security Health Plan of Wisconsin, Inc., the applicant authorizes the named group as his/her remitting agent to deduct from his/her wages or salary an amount equal to a) the existing subscription fees or b) the difference between the existing subscription fees and that contribution made by his/her employer.
- Any misrepresentation contained in this application and relied upon by the insurer may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of risk. I also understand that if I decline any coverage, future changes in coverage are NOT automatic and may be subject to the insurer's approval. I further understand and acknowledge that any person with intent to defraud or knowledge of facilitating a fraud against an insurer, submits an application or files a claim using a false and/or deceptive statement is committing a crime.
- This form is an application for coverage only. Regardless of any advance payment of premiums, the policy applied for will become effective only upon the acceptance of this application by Security Health Plan of Wisconsin, Inc., to be evidenced by the issuance of an identification card and booklet/certificate.
- Security Health Plan of Wisconsin, Inc. may request proof of documentation related to an employee's enrollment eligibility. Employee agrees to cooperate in providing any such documentation requested.

I agree that the above answers are true and complete to the best of my knowledge and are made to induce the issuance of and as part of the policy I am applying for. I apply for enrollment subject to the terms and conditions above.

Applicant's signature (required) _____

_____/_____/_____
Date (m/d/y)

If you are waiving coverage for ANYONE, make sure you sign page 3 of the application.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Complete this section if someone assisted you in the completion of this application.

The following person assisted me in completing the application _____

Explain your relationship with the applicant _____

F. Health coverage waiver

I understand that if I decline coverage at this time for my spouse/domestic partner, my dependent child(ren) or myself and apply for coverage later, I/they may need to wait for coverage until an annual enrollment date.

1. I understand that I am eligible to apply for group health insurance through my employer. I do not want, and hereby waive, group health insurance for the following individuals: (check [✓] all boxes that apply)

☐ Myself ☐ Spouse ☐ Dependent child(ren), list names _____

2. I am waiving group health insurance because: (check [✓] all boxes that apply)

☐ I (and/or any dependents) will be covered by another health benefit plan.

Name of insurance company _____

☐ The annualized premium contribution to be paid by me on behalf of myself or my dependent spouse and/or child(ren) would exceed 10% of my annualized gross earnings from this employer (applicable for small employers only).

☐ Other reason _____

Waiver:

I certify that I have been given the opportunity to apply for group health insurance and decline to enroll as indicated above, on behalf of myself, my spouse and/or my dependent child(ren). I understand that by signing this waiver, I, my spouse and/or my dependent child(ren) forfeit the right to coverage. I was not pressured, forced or unfairly induced by my employer, the agent or the insurer(s) into waiving or declining the group health insurance. If in the future I apply for coverage, I, my spouse or any of my dependent child(ren) 19 years and older may be treated as a late enrollee and subject to postponement.

I understand that if I am declining enrollment for myself, my spouse or my dependent child(ren) because of other health insurance, I may in the future be able to enroll myself, my spouse or my dependent child(ren) in this plan, provided I request enrollment within 31 days after my other health coverage ends. In addition, if I gain a dependent spouse or child(ren) as a result of marriage, birth, adoption or placement for adoption, I understand that I may be able to enroll myself, my spouse and/or my dependent child(ren), provided that I request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. I understand that I can obtain enrollment information from my employer or group health insurance carrier.

Signature _____ Date (m/d/y) ____ / ____ / ____

If you are electing coverage for yourself, please make sure you sign page 2, Section E of the application.

G. Nondiscrimination notice

Security Health Plan of Wisconsin, Inc., complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation in the administration of the plan, including enrollment and benefit determinations.

Limited English Proficiency Language Services

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

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. 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).

If you require materials in large print, call 1-800-472-2363 (TTY 711).

HIPAA Use and Disclose Protected Health Information Authorization

Form to be used if member wishes to allow release of information to a third party.

Sections A, B and D must be completed. A signature on page 2 is required to make the authorization valid.

Section A – Information about Security Health Plan member in question

Name (last, first, middle) _____ Subscriber no. _____

Address _____

Phone (_____) _____ Date of birth (m/d/y) ____ / ____ / ____

MY HEALTH INFORMATION. The health information that is subject to this authorization consists of all health information about me created or received by Security Health Plan, including the following types of records: medical, dental, alcohol and/or drug abuse, psychiatric/psychological (excluding psychotherapy notes*), developmental disabilities, case or medical management, billing, payment, claims and enrollment. It includes records of the diagnosis by a member of the medical profession of, or treatment for, acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC). It does not include any records of tests at anonymous counseling and testing sites or through the use of an anonymous home test kit to detect the presence of human immunodeficiency virus (HIV), antigen and non-antigenic products of HIV or antibody to HIV.

* Psychotherapy notes are notes recorded by a mental health professional that document or analyze the conversation during a private, group, joint or family counseling session and that are separated from the rest of my medical record. Psychotherapy notes do not include medication prescription and monitoring, counseling session start and stop times, the types and frequencies of treatment, clinical test results, or any summary of diagnosis, functional status, treatment plan, symptoms, prognosis or progress to date.

Section B – Individuals who you want to have access to your information

AUTHORIZED DISCLOSURE. I authorize Security Health Plan to disclose my health information described above to:

Name(s) _____ Relationship to member _____

Address _____ Phone (_____) _____

Name(s) _____ Relationship to member _____

Address _____ Phone (_____) _____

Name(s) _____ Relationship to member _____

Address _____ Phone (_____) _____

for the following specific purpose(s): payment matters including claim handling, prior authorization requests, membership and enrollment inquiries; health care operations including customer service, grievance or appeal matters, care coordination and additional purposes as described.

Additional names may be added to a separate page.

(continued)

Section C – Term and other information

TERM. This authorization will remain in effect until the following date or event occurs

_____, (indicate a date/event or leave blank)
or until I am no longer covered by Security Health Plan, whichever occurs earlier, unless I revoke this authorization in writing (at any time) as described in the Security Health Plan Notice of Privacy Practices (copy available upon request).

I understand Security Health Plan will not condition my enrollment or my eligibility for benefits on my providing this authorization.

I understand that once Security Health Plan discloses my health information to the person named above, in accordance with this authorization, it is possible that the information could be redisclosed by that person and no longer protected by applicable federal and state law governing the use and disclosure of my health information.

I understand that I will receive a copy of this signed authorization.

Section D – Signature

I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the disclosure of my health information. I knowingly and voluntarily authorize disclosure of my health information as described above.

Signature _____ **Date (m/d/y)** ____/____/____

If member is unable to sign this authorization, please complete the information below:

Signature of authorized legal guardian, health care agent, or other authorized personal representative _____ **Relationship** _____ **Date (m/d/y)** ____/____/____

(A copy of guardianship or other supporting documents must be provided to Security Health Plan if a signature appears here.)

Note to recipient of drug and alcohol abuse information: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Retain a copy of this authorization for your records.

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Limited English Proficiency Language Services

ATTENTION: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-998-0998 (TTY 711). Someone who speaks your preferred language can help you. This is a free service.

ATENCIÓN: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-998-0998 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

LUS CEEV: Peb muaj kev pab txhais lus dawb los teb cov lus nug uas koj muaj txog peb txoj kev npaj khomob lossis tshuaj. Yog xav tau ib tug neeg txhais lus, tsuas yog hu rau peb ntawm 1-877-998-0998 (TTY 711). Ib tus neeg hais lus koj nyiam tuaj yeem pab koj. Qhov no yog ib qho kev pab dawb.

If you require materials in large print, call 1-877-998-0998 (TTY 711).

Out-of-area Dependent Coverage Verification

We are taking steps to ensure your covered spouse's and/or child(ren)'s claims are processed correctly and you receive the out-of-area dependent coverage benefit while they are residing outside our service area. We need a few pieces of information from you to make sure any medical services they receive while outside the service area will be processed as if the services were incurred in the service area.

Steps needed to qualify:

1. Confirm eligibility. Your family members are eligible for out-of-area dependent coverage if you, the subscriber, reside in the service area of your plan, and a covered spouse or dependent resides outside.
2. Complete the information below to be sure you receive the out-of-area dependent coverage benefit.
3. Email this form to Enrollment Services at shpmember@securityhealth.org. You may also update a dependent's address on your My Security Health portal account or call Customer Service at 1.800.472.2363 or 715.221.9555 (TTY 711) Monday through Friday from 7:00 a.m. to 5:30 p.m.

Employee _____ Email _____

Complete the following for spouse and/or child(ren) residing outside the service area. If this affects more than one person on your health plan, provide information for each person. Attach an additional sheet if necessary.

Name _____ DOB (m/d/y) ____ / ____ / ____

Address _____

City _____ State _____ ZIP _____

Phone _____

Failure to provide the requested information will result in claims being paid with the out-of-network benefit.

Security Health Plan pays out-of-network providers based on our Usual, Customary and Reasonable (UCR) fee schedule, subject to applicable deductible, coinsurance and copayment amounts. If a charge exceeds our UCR fee limit, we may reimburse less than the billed charge. The member is responsible for any amount charged in excess of such fees, as well as applicable deductible, coinsurance and copayment amounts. Any amount not covered by the UCR fee schedule and paid by the member does not count toward the maximum out-of-pocket limit for the plan.

Healthy Living Reimbursement Request

Security Health Plan offers a healthy living benefit to reward eligible members for engaging in health and well-being activities. Subscribers, their spouses and adult dependents (18 and older) may submit this form for reimbursement of eligible purchases. Limit, two members per family.

Reimbursement request instructions:

- Members may only submit **one** reimbursement form each calendar year.
- Copies of paid receipts or bank/credit card statements submitted with this form must include a description of the purchase, price and date. You must be a Security Health Plan member on the date of purchase and receipt dates must match the year you are requesting reimbursement.
- A separate form is required for each eligible member 18 and older requesting reimbursement. Reimbursement is limited to \$200 per family; \$100 per member. Members with a family membership may be reimbursed up to \$200 for the same purchase (i.e. annual fitness center membership). Each member must submit a separate form and include a copy of the same receipt.
- Reimbursement requests must be received no later than March 31 of the following year in which expenses were incurred. Requests received on or after April 1 for previous calendar year expenses will not be accepted. You must have been an eligible member for the benefit when the purchase was made.

STEP 1: Enter calendar year you are requesting reimbursement.

STEP 2: Member requesting reimbursement _____

Employer/Sponsor name _____

Subscriber number _____

Member number _____

(This is the number to the left of your name.)

Date of birth _____

(Fill out the information as it is listed on your medical ID card.)

Member home address _____

SecurityHealth PlanSM

Medical Card

Subscriber #: 050012345800

Grp#: 987654 HMO

00123456 John T Doe 7/26/1970

00234567 Jane E Doe 2/07/1972

001234567 Jim T Doe 6/29/2001

Security Health Plan Customer Service 1.800.472.2363

Date Issued 01/01/2022

STEP 3: Include a copy of the paid receipts or bank/credit card statements with this form and mail or email to Security Health Plan. Checks will be made payable to the subscriber.

Mail: Security Health Plan
Attn: Claims Department
P.O. Box 8000
Marshfield, WI 54449-8000

Email: rf.shpmain@securityhealth.org

STEP 4: Signature: I attest this reimbursement is for services and/or equipment for my personal use.

Signature _____

Date (month/day/year) _____

Continued on back

FOR INTERNAL USE ONLY

HA Completion TIN 39-1541217 CPT S9970 Dx code Y93.89 POS 99

Date of service _____ / _____ / _____ Amount _____

About the healthy living reimbursement

Security Health Plan offers a healthy living reimbursement to reward members for engaging in health and well-being activities. Subscribers, their spouses or adult dependents (18 and older) are eligible for this benefit.

Members might be reimbursed up to \$100 maximum per member per calendar year (\$200 maximum per family per calendar year). Members cannot be reimbursed for more than the cost incurred (including applicable taxes and shipping and handling fees) for memberships, classes and equipment.

This benefit is available through certain employer-sponsored plans. Check your Certificate Amendment to see if you are eligible and for additional information about the healthy living reimbursement. Your amendment can be found with your policy materials or through My Security Health Plan.

Activities and equipment that might be eligible for reimbursement:

- Nutrition or wellness class
- Gym or health club membership
- Exercise class or personal trainer
- Weight-loss program
- *Adults only (age 18 years and older):* Swim instruction or water exercise class
- Online fitness memberships (i.e. Beachbody, Weight Watchers Online)
- Home exercise equipment that provides a total-body workout*. Equipment must be new and purchased from a retail company.

**Treadmills, stationary cycles, bike stands (to convert road bike to stationary cycle), stair climbing machines, elliptical machines, rowing machines, cross-country ski machines, total body weight resistance machines*

Activities and equipment NOT eligible for reimbursement

- Pool-only facilities (unless as part of a swim instruction or water exercise class)
- Social clubs
- Greens/Race fees
- Transportation
- Association memberships
- Lodging
- Meal plans: food, shakes, and supplements
- Fitness clothing and uniforms
- Activities that are reimbursable under the member's insurance plan
- Muscle-specific resistance equipment such as abdominal rollers, thigh or buttocks machines; exercise mats; free weights; outdoor recreational equipment such as golf clubs, bicycles, game balls, skates, skis, tennis racquets, or rollerblades; and any used equipment
- Sport or activity fees for dependent children

If you have any questions, please contact Security Health Plan's Customer Service Department at 1-800-472-2363.

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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).

If you require materials in large print, call 1-800-472-2363 (TTY 711).

Special enrollment rights notice

Federal law (called HIPAA) requires we tell you about a very important provision in your plan. This provision provides a right to enroll under "special enrollment provisions" if you acquire a new dependent, or if you or an eligible dependent declines coverage under this plan because of alternative coverage and later such coverage terminates.

Special enrollment provisions

Rule 1 - Loss of other coverage

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage and indicate that reason in writing when declining coverage, you may be able to enroll yourself and/or your dependents in this plan should the other coverage terminate or employer contributions for that coverage terminate. However, you must request enrollment within 31 days after your coverage ends or employer contributions stop, and meet certain other conditions described in your group policy.

This rule also includes people who request enrollment under the plan within 60 days after the loss of eligibility for Medicaid, including BadgerCare Plus or Children's Health Insurance Program (CHIP); or people who request enrollment under the plan within 60 days after eligibility for premium assistance subsidy under Medicaid, including BadgerCare Plus or CHIP has been determined.

Rule 2 - Marriage, birth or adoption

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you might be able to enroll yourself, your spouse and your newly acquired dependents, provided you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption, and that you meet certain other important conditions described in your group policy. (Under Wisconsin law, additional time for enrollment is available for certain situations. Notice of a newborn shall be given as soon as possible and within one year. Notice of adopted child shall be given within 60 days of adoption or placement.)

Your employer may offer a way for you to decline coverage either online or through another electronic form. In that case, Security Health Plan will accept the employer's electronic record if you decline coverage, and you would not need to fill out a paper form.

To request special enrollment or to obtain more information, contact your employer.

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