## Schedule of Benefits – HMO Premier

**Group - 701915 - STANLEY BOYD SCHOOL DISTRICT**
**Benefit Year: January 1st through December 31st**
**Effective Date: 01/01/2024**

SecurityHealth Plan℠
Promises kept, plain and simple.®

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**<br>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. | $3,250 per individual<br>$6,500 per family<br><br>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. |
| **Coinsurance** | 20% |
| **Annual out-of-pocket**<br>(Deductible, coinsurance & copayments) | $6,350 per individual<br>$12,700 per family<br><br>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**<br>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 and coinsurance |
| **Anesthesia services** | Subject to deductible and coinsurance |

| Your Benefits | |
|---|---|
| **Breast cancer (BRCA 1 & 2) gene screening**<br>*~Requires prior authorization* | Covered at 100%<br><br>(Limited to 1 visit per lifetime) |
| **Care my way** | Covered at 100% |
| **Chiropractic services** | Subject to deductible and coinsurance |
| **Dry needling** | Subject to deductible and coinsurance<br><br>(Limited to 20 visits per individual per calendar year) |
| **Durable medical equipment and medical supplies**<br>*~Requires prior authorization* | |
| • **Approved to be dispensed from a supplier** | Subject to deductible and coinsurance |
| • **Approved to be dispensed from a network pharmacy** | Refer to pharmacy benefit for pharmacy cost-share |
| **Emergency services** | |
| • **Emergency room facility** | Subject to deductible and coinsurance |
| • **Other emergency services** | Subject to deductible and coinsurance |
| **Habilitative therapy** | |
| • **Occupational therapy**<br>*~Requires prior authorization* | Subject to deductible and coinsurance |
| • **Physical therapy**<br>*~Requires prior authorization* | Subject to deductible and coinsurance |
| • **Speech therapy**<br>*~Requires prior authorization* | Subject to deductible and coinsurance |
| **Hearing examinations** | Subject to deductible and coinsurance |
| **Home health care**<br>*~Requires prior authorization* | Subject to deductible and coinsurance<br><br>(Limited to 40 visits per individual per calendar year) |
| **Hospice care** | Subject to deductible and coinsurance |
| **Hospital services** | |
| • **Inpatient hospital services**<br>(Including semi-private or special care room, operating room, ancillary services and supplies)<br>*~Requires prior authorization* | Subject to deductible and coinsurance |

| Your Benefits | |
|---|---|
| • **Inpatient/residential mental health and substance use disorder services**<br>*~Requires prior authorization* | Subject to deductible and coinsurance |
| • **Outpatient hospital and surgical services**<br>(not including emergency room) | Subject to deductible and coinsurance |
| • **Physician hospital services** | Subject to deductible and coinsurance |
| • **Other hospital services** | Subject to deductible and coinsurance |
| **Infusion therapy** | |
| • **Home infusion services**<br>(when medically appropriate and provider available) | Subject to deductible and coinsurance |
| • **Outpatient services** | Subject to deductible and coinsurance |
| **Maternity services** | |
| • **Hospital services** | Subject to deductible and coinsurance |
| • **Physician services** | Subject to deductible and coinsurance |
| **Mental health and substance use disorder services** | |
| • **Outpatient care** | Subject to deductible and coinsurance |
| • **Transitional care** | Subject to deductible and coinsurance |
| **Nutritional counseling** | Subject to deductible and coinsurance |
| **Outpatient laboratory services** | Subject to deductible and coinsurance |
| **Outpatient radiology services** | Subject to deductible and coinsurance |
| **Physician services** | |
| • **Office visits** | Subject to deductible and coinsurance<br><br>(Preventive exams covered at 100%) |
| • **Office visits with primary care physician (PCP)** | Subject to deductible and coinsurance<br><br>(Preventive exams covered at 100%) |
| • **Office visits with specialist** | Subject to deductible and coinsurance |
| • **Other physician services in an office** | Subject to deductible and coinsurance<br><br>(Preventive immunizations covered at 100%) |

| Your Benefits | |
|---|---|
| **Preventive care services**<br>Please visit www.securityhealth.org/preventive or call 1-800-472-2363 for information on service frequency recommendations and a list of preventive screening services.<br><br>Tests for an existing condition or illness are not preventive care and are subject to your plan's deductible, coinsurance and/or copays. | Scan this code with your smartphone |
| • **Wellness visit**<br>(comprehensive physical examination)<br>○ Well-baby care<br>○ Well-child care<br>○ Well-adolescent care<br>○ Well-adult care<br>○ Interpersonal and domestic violence screening<br>○ Nutritional screening<br>○ Screening and counseling for sexually transmitted infections | Covered at 100% |
| • **Abdominal aortic aneurysm (ultrasound) screening**<br>(age 65 thru 75) | Covered at 100%<br><br>(Limited to 1 visit per lifetime) |
| • **Breast feeding support and counseling** | Covered at 100% |
| • **Cervical cancer screenings**<br>(age 21 thru 65) | |
| ○ Human papillomavirus DNA screening (HPV) | 1 every five years then subject to deductible and coinsurance |
| ○ Pap smear screening | 1 every three years then subject to deductible and coinsurance |
| • **Chlamydia screening** | 1 per calendar year then subject to deductible and coinsurance |
| • **Colorectal cancer screenings** | |
| ○ Colonoscopy screening<br>(age 45 and older) | 1 every five years then subject to deductible and coinsurance |
| ○ Colonoscopy screening for personal or family history of polyps or colorectal cancer | 1 every two years then subject to deductible and coinsurance |
| ○ Sigmoidoscopy screening<br>(age 45 and older) | 1 every five years then subject to deductible and coinsurance |

| Your Benefits | |
|---|---|
| ○ Sigmoidoscopy screening for personal or family history of polyps or colorectal cancer | 1 every two years then subject to deductible and coinsurance |
| ○ Other colorectal cancer screenings<br>~Fecal occult blood testing<br>(age 45 and older) | 1 per calendar year then subject to deductible and coinsurance |
| • **Gynecological examination**<br>(breast exam and pelvic exam) | 1 per calendar year then subject to deductible and coinsurance |
| • **Hearing screening**<br>(under age 22) | 1 per calendar year then subject to deductible and coinsurance |
| • **Immunizations and vaccinations**<br>(including those needed for travel) | Covered at 100% |
| • **Laboratory screening services**<br>Please visit www.securityhealth.org/preventive or call 1-800-472-2363 for information on service frequency recommendations and screening laboratory services. | |
| ○ Cholesterol screening<br>(age 40 thru 75) | 1 per calendar year then subject to deductible and coinsurance |
| ○ Diabetes Type 2 screening<br>(age 35 thru 70 with BMI 30+) | 1 per calendar year then subject to deductible and coinsurance |
| ○ Hemoglobin (A1C)<br>(diabetics) | 2 per calendar year then subject to deductible and coinsurance |
| ○ Lead screening<br>(age 1 thru 6) | 1 per calendar year then subject to deductible and coinsurance |
| • **Mammogram to screen for breast cancer**<br>(includes 2D and 3D imaging) | 1 per calendar year then subject to deductible and coinsurance |
| • **Osteoporosis screening**<br>Bone mineral density (dexa scan) | 1 every two years then subject to deductible and coinsurance |
| • **Prostate cancer screenings** | |
| ○ Digital examination | Subject to deductible and coinsurance |
| ○ Prostate specific antigen test (PSA)<br>(age 55 thru 69) | 1 per calendar year then subject to deductible and coinsurance |
| • **Vision screenings** | |
| ○ Comprehensive pediatric/adolescent vision examination<br>(under age 19) | Subject to deductible and coinsurance |

| **Your Benefits** | |
|---|---|
| ○ Visual impairment screening (age 1 thru 5) | 1 per calendar year then subject to deductible and coinsurance |
| **Rehabilitative therapy** | |
| • **Occupational therapy** *~Requires prior authorization* | Subject to deductible and coinsurance |
| • **Physical therapy** *~Requires prior authorization* | Subject to deductible and coinsurance |
| • **Speech therapy** *~Requires prior authorization* | Subject to deductible and coinsurance |
| **Skilled nursing facility** *~Requires prior authorization* | Subject to deductible and coinsurance<br><br>(Limited to 30 days per individual per confinement) |
| **Surgical services** | Subject to deductible and coinsurance |
| **Temporomandibular joint disorders or TMJ non-surgical treatment** *~Requires prior authorization* | Subject to deductible and coinsurance<br><br>(Limited to 4 physical/occupational visits for diagnosis of TMJ per year) |
| **Transplant services** *~Requires prior authorization* | Subject to deductible and coinsurance |
| **Urgent care services** | |
| • **Urgent care office visits** | Subject to deductible and coinsurance |
| • **Other urgent care services** | Subject to deductible and coinsurance |
| **Vision examinations** (age 19 and over) | Subject to deductible and coinsurance |

| **Pharmacy** | |
|---|---|
| • 100% coverage for preventive prescription drugs (not subject to deductible).Please refer to the Preventive Medication List for a list of covered products.<br>• 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.<br>• 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.<br>• 100% coverage for smoking cessation products, limited to 180 days per year.<br>• The use of a specialty pharmacy may be required for select prescription drugs, as indicated in the Formulary Guide.<br>• Prescription drugs may require prior authorization.<br>• Please refer to our website at www.securityhealth.org/prescription-tools for the most up-to-date prescription drug lists.<br>• Eligible subscribers will receive a quarterly over-the-counter (OTC) credit.<br>  ○ Please refer to www.securityhealth.org/OTC or call 1-877-216-8533 for benefit information and list of products. | Subject to deductible.<br><br>After deductible, the following copayments and/or coinsurance apply to covered prescription drugs until the maximum out-of-pocket is met.<br><br>$5 copayment per tier 1 prescription or refill.<br><br>$25 copayment per tier 2 prescription or refill.<br><br>$50 copayment per tier 3 prescription or refill.<br><br>25% coinsurance per tier 4 prescription or refill (specialty prescription drugs).<br><br>Deductible, copayments and coinsurance may apply to the max out of pocket amounts.<br><br>If the member receives the brand name prescription drug where a generic is available, the member 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.<br><br>In addition, a child who meets the criteria above and is a full-time student as defined in this policy has an extension past age 26, if the child was called to federal active duty in the National Guard or in reserve component of the U.S. armed forces while the child was under age 27 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 policy and any previous amendments. |

**Prior Authorization**

Note: It is your responsibility to ensure that the prior authorization is obtained and completed by your health care provider.

Your health care provider should start the prior authorization process by visiting www.securityhealth.org/providers or contact our Provider Assistance Line at 1-800-548-1224.

You can also call our Customer Service Department at 1-800-472-2363 to find out what medical services require prior authorization.

For a complete list of medical and pharmacy services requiring prior authorizations visit www.securityhealth.org/authorization or scan the QR code with your smartphone.

Scan this code with your smartphone

**Notice of Nondiscrimination**

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, disability, age, sex, gender identity, sexual orientation, 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, please call 1-800-472-2363 (TTY 711).

## Schedule of Benefits – HMO SimplyOne

**Group - 101089 - STANLEY BOYD SCHOOL DISTRICT**
**Benefit Year: January 1st through December 31st**
**Effective Date: 01/01/2024**

SecurityHealth Plan℠
Promises kept, plain and simple.®

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**<br>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. | $3,250 per individual<br>$6,500 per family<br><br>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. |
| **Coinsurance** | 20% |
| **Annual out-of-pocket**<br>(Deductible, coinsurance & copayments) | $6,350 per individual<br>$12,700 per family<br><br>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**<br>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 and coinsurance |
| **Anesthesia services** | Subject to deductible and coinsurance |

| Your Benefits | |
|---|---|
| **Breast cancer (BRCA 1 & 2) gene screening**<br>*~Requires prior authorization* | Covered at 100%<br><br>(Limited to 1 visit per lifetime) |
| **Care my way** | Covered at 100% |
| **Chiropractic services** | Subject to deductible and coinsurance |
| **Dry needling** | Subject to deductible and coinsurance<br><br>(Limited to 20 visits per individual per calendar year) |
| **Durable medical equipment and medical supplies**<br>*~Requires prior authorization* | |
| • **Approved to be dispensed from a supplier** | Subject to deductible and coinsurance |
| • **Approved to be dispensed from a network pharmacy** | Refer to pharmacy benefit for pharmacy cost-share |
| **Emergency services** | |
| • **Emergency room facility** | Subject to deductible and coinsurance |
| • **Other emergency services** | Subject to deductible and coinsurance |
| **Habilitative therapy** | |
| • **Occupational therapy**<br>*~Requires prior authorization* | Subject to deductible and coinsurance |
| • **Physical therapy**<br>*~Requires prior authorization* | Subject to deductible and coinsurance |
| • **Speech therapy**<br>*~Requires prior authorization* | Subject to deductible and coinsurance |
| **Hearing examinations** | Subject to deductible and coinsurance |
| **Home health care**<br>*~Requires prior authorization* | Subject to deductible and coinsurance<br><br>(Limited to 40 visits per individual per calendar year) |
| **Hospice care** | Subject to deductible and coinsurance |
| **Hospital services** | |
| • **Inpatient hospital services**<br>(Including semi-private or special care room, operating room, ancillary services and supplies)<br>*~Requires prior authorization* | Subject to deductible and coinsurance |

| Your Benefits | |
|---|---|
| • **Inpatient/residential mental health and substance use disorder services**<br>*~Requires prior authorization* | Subject to deductible and coinsurance |
| • **Outpatient hospital and surgical services**<br>(not including emergency room) | Subject to deductible and coinsurance |
| • **Physician hospital services** | Subject to deductible and coinsurance |
| • **Other hospital services** | Subject to deductible and coinsurance |
| **Infusion therapy** | |
| • **Home infusion services**<br>(when medically appropriate and provider available) | Subject to deductible and coinsurance |
| • **Outpatient services** | Subject to deductible and coinsurance |
| **Maternity services** | |
| • **Hospital services** | Subject to deductible and coinsurance |
| • **Physician services** | Subject to deductible and coinsurance |
| **Mental health and substance use disorder services** | |
| • **Outpatient care** | Subject to deductible and coinsurance |
| • **Transitional care** | Subject to deductible and coinsurance |
| **Nutritional counseling** | Subject to deductible and coinsurance |
| **Outpatient laboratory services** | Subject to deductible and coinsurance |
| **Outpatient radiology services** | Subject to deductible and coinsurance |
| **Physician services** | |
| • **Office visits** | Subject to deductible and coinsurance<br><br>(Preventive exams covered at 100%) |
| • **Office visits with primary care physician (PCP)** | Subject to deductible and coinsurance<br><br>(Preventive exams covered at 100%) |
| • **Office visits with specialist** | Subject to deductible and coinsurance |
| • **Other physician services in an office** | Subject to deductible and coinsurance<br><br>(Preventive immunizations covered at 100%) |

| Your Benefits | |
|---|---|
| **Preventive care services**<br>Please visit www.securityhealth.org/preventive or call 1-800-472-2363 for information on service frequency recommendations and a list of preventive screening services.<br><br>Tests for an existing condition or illness are not preventive care and are subject to your plan's deductible, coinsurance and/or copays. | Scan this code with your smartphone |
| • **Wellness visit**<br>(comprehensive physical examination)<br>○ Well-baby care<br>○ Well-child care<br>○ Well-adolescent care<br>○ Well-adult care<br>○ Interpersonal and domestic violence screening<br>○ Nutritional screening<br>○ Screening and counseling for sexually transmitted infections | Covered at 100% |
| • **Abdominal aortic aneurysm (ultrasound) screening**<br>(age 65 thru 75) | Covered at 100%<br><br>(Limited to 1 visit per lifetime) |
| • **Breast feeding support and counseling** | Covered at 100% |
| • **Cervical cancer screenings**<br>(age 21 thru 65) | |
| ○ Human papillomavirus DNA screening (HPV) | 1 every five years then subject to deductible and coinsurance |
| ○ Pap smear screening | 1 every three years then subject to deductible and coinsurance |
| • **Chlamydia screening** | 1 per calendar year then subject to deductible and coinsurance |
| • **Colorectal cancer screenings** | |
| ○ Colonoscopy screening<br>(age 45 and older) | 1 every five years then subject to deductible and coinsurance |
| ○ Colonoscopy screening for personal or family history of polyps or colorectal cancer | 1 every two years then subject to deductible and coinsurance |
| ○ Sigmoidoscopy screening<br>(age 45 and older) | 1 every five years then subject to deductible and coinsurance |

| Your Benefits | |
|---|---|
| ○ Sigmoidoscopy screening for personal or family history of polyps or colorectal cancer | 1 every two years then subject to deductible and coinsurance |
| ○ Other colorectal cancer screenings<br>~Fecal occult blood testing<br>(age 45 and older) | 1 per calendar year then subject to deductible and coinsurance |
| • **Gynecological examination**<br>(breast exam and pelvic exam) | 1 per calendar year then subject to deductible and coinsurance |
| • **Hearing screening**<br>(under age 22) | 1 per calendar year then subject to deductible and coinsurance |
| • **Immunizations and vaccinations**<br>(including those needed for travel) | Covered at 100% |
| • **Laboratory screening services**<br>Please visit www.securityhealth.org/preventive or call 1-800-472-2363 for information on service frequency recommendations and screening laboratory services. | |
| ○ Cholesterol screening<br>(age 40 thru 75) | 1 per calendar year then subject to deductible and coinsurance |
| ○ Diabetes Type 2 screening<br>(age 35 thru 70 with BMI 30+) | 1 per calendar year then subject to deductible and coinsurance |
| ○ Hemoglobin (A1C)<br>(diabetics) | 2 per calendar year then subject to deductible and coinsurance |
| ○ Lead screening<br>(age 1 thru 6) | 1 per calendar year then subject to deductible and coinsurance |
| • **Mammogram to screen for breast cancer**<br>(includes 2D and 3D imaging) | 1 per calendar year then subject to deductible and coinsurance |
| • **Osteoporosis screening**<br>Bone mineral density (dexa scan) | 1 every two years then subject to deductible and coinsurance |
| • **Prostate cancer screenings** | |
| ○ Digital examination | Subject to deductible and coinsurance |
| ○ Prostate specific antigen test (PSA)<br>(age 55 thru 69) | 1 per calendar year then subject to deductible and coinsurance |
| • **Vision screenings** | |
| ○ Comprehensive pediatric/adolescent vision examination<br>(under age 19) | Subject to deductible and coinsurance |

| **Your Benefits** | |
|---|---|
| ○ Visual impairment screening (age 1 thru 5) | 1 per calendar year then subject to deductible and coinsurance |
| **Rehabilitative therapy** | |
| • **Occupational therapy** *~Requires prior authorization* | Subject to deductible and coinsurance |
| • **Physical therapy** *~Requires prior authorization* | Subject to deductible and coinsurance |
| • **Speech therapy** *~Requires prior authorization* | Subject to deductible and coinsurance |
| **Skilled nursing facility** *~Requires prior authorization* | Subject to deductible and coinsurance<br><br>(Limited to 30 days per individual per confinement) |
| **Surgical services** | Subject to deductible and coinsurance |
| **Temporomandibular joint disorders or TMJ non-surgical treatment** *~Requires prior authorization* | Subject to deductible and coinsurance<br><br>(Limited to 4 physical/occupational visits for diagnosis of TMJ per year) |
| **Transplant services** *~Requires prior authorization* | Subject to deductible and coinsurance |
| **Urgent care services** | |
| • **Urgent care office visits** | Subject to deductible and coinsurance |
| • **Other urgent care services** | Subject to deductible and coinsurance |
| **Vision examinations** (age 19 and over) | Subject to deductible and coinsurance |

| **Pharmacy** | |
|---|---|
| • 100% coverage for preventive prescription drugs (not subject to deductible). Please refer to the Preventive Medication List for a list of covered products.<br>• Up to 30 days worth of prescription drugs constitutes a 1-month supply. If filled at any Marshfield Clinic Pharmacy location, 1/2 copay will be assessed for tiers 1, 2 or 3, if applicable.<br>• For most maintenance prescription drugs you may receive up to a 90-day supply and 1 1/2 copayments will be assessed at any Marshfield Clinic Pharmacy location. If filled at a non-Marshfield Clinic location 2 copayments will be assessed.<br>• 100% coverage for smoking cessation products, limited to 180 days per year.<br>• The use of a specialty pharmacy may be required for select prescription drugs, as indicated in the Formulary Guide.<br>• Prescription drugs may require prior authorization.<br>• Please refer to our website at www.securityhealth.org/prescription-tools for the most up-to-date prescription drug lists.<br>• Eligible subscribers will receive a quarterly over-the-counter (OTC) credit.<br>  ○ Please refer to www.securityhealth.org/OTC or call 1-877-216-8533 for benefit information and list of products. | Subject to deductible.<br><br>After deductible, the following copayments and/or coinsurance apply to covered prescription drugs until the maximum out-of-pocket is met.<br><br>$5 copayment per tier 1 prescription or refill.<br><br>$25 copayment per tier 2 prescription or refill.<br><br>$50 copayment per tier 3 prescription or refill.<br><br>25% coinsurance per tier 4 prescription or refill (specialty prescription drugs).<br><br>Deductible, copayments and coinsurance may apply to the max out of pocket amounts.<br><br>If the member receives the brand name prescription drug where a generic is available, the member 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.<br><br>In addition, a child who meets the criteria above and is a full-time student as defined in this policy has an extension past age 26, if the child was called to federal active duty in the National Guard or in reserve component of the U.S. armed forces while the child was under age 27 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 policy and any previous amendments. |

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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).

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