Schedule of Benefits – HMO Premier

Group - 720671 - CORNELL SCHOOL DISTRICT
Benefit Year: January 1st through December 31st
Effective Date: 07/01/2024

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 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.	$3,200 per individual $6,400 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)	$3,200 per individual $6,400 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
Breast cancer (BRCA 1 & 2) gene screening *~Requires prior authorization*	Covered at 100% (Limited to 1 visit per lifetime)

Your Benefits	
Care my way	Covered at 100%
Chiropractic services	Subject to deductible
Dry needling	Subject to deductible (Limited to 20 visits per individual per calendar year)
Durable medical equipment and medical supplies *~Requires prior authorization*	
• **Approved to be dispensed from a supplier**	Subject to deductible
• **Approved to be dispensed from a network pharmacy**	Refer to pharmacy benefit for pharmacy cost-share
Emergency services	
• **Emergency room facility**	Subject to deductible
• **Other emergency services**	Subject to deductible
Habilitative therapy	
• **Occupational therapy** *~Requires prior authorization*	Subject to deductible
• **Physical therapy** *~Requires prior authorization*	Subject to deductible
• **Speech therapy** *~Requires prior authorization*	Subject to deductible
Hearing examinations	Subject to deductible
Home health care *~Requires prior authorization*	Subject to deductible (Limited to 40 visits per individual per calendar year)
Hospice care	Subject to deductible
Hospital services	
• **Inpatient hospital services** (Including semi-private or special care room, operating room, ancillary services and supplies) *~Requires prior authorization*	Subject to deductible
• **Inpatient/residential mental health and substance use disorder services** *~Requires prior authorization*	Subject to deductible
• **Outpatient hospital and surgical services** (not including emergency room)	Subject to deductible

Your Benefits	
• **Physician hospital services**	Subject to deductible
• **Other hospital services**	Subject to deductible
Infusion therapy	
• **Home infusion services** (when medically appropriate and provider available)	Subject to deductible
• **Outpatient services**	Subject to deductible
Maternity services	
• **Hospital services**	Subject to deductible
• **Physician services**	Subject to deductible
Mental health and substance use disorder services	
• **Outpatient care**	Subject to deductible
• **Transitional care**	Subject to deductible
Nutritional counseling	Subject to deductible
Outpatient laboratory services	Subject to deductible
Outpatient radiology services	Subject to deductible
Physician services	
• **Office visits**	Subject to deductible (Preventive exams covered at 100%)
• **Office visits with primary care physician (PCP)**	Subject to deductible (Preventive exams covered at 100%)
• **Office visits with specialist**	Subject to deductible
• **Other physician services in an office**	Subject to deductible (Preventive immunizations covered at 100%)

Your Benefits	
Preventive care services 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. 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** (comprehensive physical examination) ○ Well-baby care ○ Well-child care ○ Well-adolescent care ○ Well-adult care ○ Interpersonal and domestic violence screening ○ Nutritional screening ○ Screening and counseling for sexually transmitted infections	Covered at 100%
• **Abdominal aortic aneurysm (ultrasound) screening** (age 65 thru 75)	Covered at 100% (Limited to 1 visit per lifetime)
• **Breast feeding support and counseling**	Covered at 100%
• **Cervical cancer screenings** (age 21 thru 65)	
○ Human papillomavirus DNA screening (HPV)	1 every five years then subject to deductible
○ Pap smear screening	1 every three years then subject to deductible
• **Chlamydia screening**	1 per calendar year then subject to deductible
• **Colorectal cancer screenings**	
○ Colonoscopy screening (age 45 and older)	1 every five years then subject to deductible
○ Colonoscopy screening for personal or family history of polyps or colorectal cancer	1 every two years then subject to deductible
○ Sigmoidoscopy screening (age 45 and older)	1 every five years then subject to deductible
○ Sigmoidoscopy screening for personal or family history of polyps or colorectal cancer	1 every two years then subject to deductible

Your Benefits	
○ Other colorectal cancer screenings ~Fecal occult blood testing (age 45 and older)	1 per calendar year then subject to deductible
• **Gynecological examination** (breast exam and pelvic exam)	1 per calendar year then subject to deductible
• **Hearing screening** (under age 22)	1 per calendar year then subject to deductible
• **Immunizations and vaccinations** (including those needed for travel)	Covered at 100%
• **Laboratory screening services** For a complete list of screening laboratory services and frequency recommendations please refer to Security Health Plan's Preventive Service Guidelines at www.securityhealth.org/preventive or contact us at 1-800-472-2363.	
○ Cholesterol screening (age 40 thru 75)	1 per calendar year then subject to deductible
○ Diabetes Type 2 screening (age 35 thru 70 with BMI 30+)	1 per calendar year then subject to deductible
○ Hemoglobin (A1C) (diabetics)	2 per calendar year then subject to deductible
○ Lead screening (age 1 thru 6)	1 per calendar year then subject to deductible
• **Mammogram to screen for breast cancer** (includes 2D and 3D imaging)	1 per calendar year then subject to deductible
• **Osteoporosis screening** Bone mineral density (dexa scan)	1 every two years then subject to deductible
• **Prostate cancer screenings**	
○ Digital examination	Subject to deductible
○ Prostate specific antigen test (PSA) (age 55 thru 69)	1 per calendar year then subject to deductible
• **Vision screenings**	
○ Comprehensive pediatric/adolescent vision examination (under age 19)	Subject to deductible

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

Pharmacy	
• 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. • 100% coverage for diabetic testing supplies found on the Diabetic List (not subject to deductible). • $25 maximum copay per month on insulin products found on the Diabetic list (not subject to deductible). • 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. • 100% coverage for select Selective Serotonin Reuptake Inhibitors (SSRIs) (not subject to deductible). • Prescription drugs may require prior authorization. • Please refer to our website at www.securityhealth.org/prescription-tools for the most up-to-date prescription drug lists. • Eligible subscribers will receive a quarterly over-the-counter (OTC) credit. ○ Please refer to www.securityhealth.org/OTC or call 1-877-216-8533 for benefit information and list of products.	Subject to deductible. Deductible, copayments and coinsurance may apply to the max out of pocket amounts. 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. 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).