Schedule of Benefits - HMO Premier

Group 701915 - STANLEY BOYD SCHOOL DISTRICT
Benefit Year: January 1st through December 31st
Effective Date: 01/01/2021

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.	$3,250 per individual $6,500 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.
Coinsurance	20%
Annual out-of-pocket (Deductible, coinsurance & copayments)	$6,350 per individual $12,700 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 and coinsurance
Anesthesia services	Subject to deductible and coinsurance
Care my way	Covered at 100%
Chiropractic services	Subject to deductible and coinsurance
Dry needling	Subject to deductible and coinsurance (Limited to 20 visits per individual per calendar year)
Durable medical equipment and medical supplies (Including insulin pump and supplies) *~ Requires prior authorization*	Subject to deductible and coinsurance

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Your Benefits	
Habilitative 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
Hearing examinations	Subject to deductible and coinsurance
Home health care *~ Requires prior authorization*	Subject to deductible and coinsurance (Limited to 40 visits per individual per calendar year)
Hospice care	Subject to deductible and coinsurance
Hospital emergency room services	Subject to deductible and coinsurance
Hospital inpatient services (Including semi-private or special care room, operating room, ancillary services and supplies)	Subject to deductible and coinsurance
Hospital outpatient and surgical center services (Not including emergency room)	Subject to deductible and coinsurance
Infusion therapy	
• **Outpatient services**	Subject to deductible and coinsurance
• **Home infusion services** (when medically appropriate and provider available)	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	
• **Inpatient care**	Subject to deductible and coinsurance
• **Outpatient care**	Subject to deductible and coinsurance
• **Transitional care**	Subject to deductible and coinsurance
Nutritional counseling	Covered at 100% (Limited to 4 visits per calendar year)
Office visits	Subject to deductible and coinsurance (Preventive exams covered at 100%)

Your Benefits	
Outpatient laboratory services	Subject to deductible and coinsurance
Outpatient radiology services	Subject to deductible and coinsurance
Physician services	
• **Hospital services**	Subject to deductible and coinsurance
• **Other services in an office**	Subject to deductible and coinsurance (Preventive immunizations covered at 100%)

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. • Prescription drugs may require prior authorization. The most up-to-date prescription drug list can be found on our website at www.securityhealth.org/prescription-tools	Subject to deductible. After deductible, the following copayments and/or coinsurance apply to covered prescription drugs until the maximum out-of-pocket is met. $5 copayment per tier 1 prescription or refill. $25 copayment per tier 2 prescription or refill. $50 copayment per tier 3 prescription or refill. 25% coinsurance per TIER 4 prescription or refill (specialty prescription drugs). Deductible, copayments and coinsurance may apply to the max out of pocket amounts. 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.