SecurityHealth Plan℠
Security Administrative Services

Clark County
Group Numbers: 4004
Effective Date: January 1, 2018
Benefit Year: January-December
Non-Grandfathered Plan

SCHEDULE OF BENEFITS
Base Plan

This schedule is provided as a convenience only and is not all-inclusive. Important information is contained in your Summary Plan Description. Please note all Out-of-Network Provider charges are subject to usual, customary and reasonable fees. It is strongly recommended that you read the entire Summary Plan Description to ensure a complete understanding of the Plan provisions. You may also contact the third party administrator or the Plan Administrator for assistance.

Your Responsibilities	In network	Out of network
Deductible The individual Deductible does not apply under a family plan. One or more members must meet the family deductible before benefits will be paid.	$2,000 individual $4,000 family	$4,000 individual $8,000 family
Coinsurance	20%	40%
Annual out of pocket (Deductible & coinsurance) In-network amounts accumulate to the out-of-network out-of-pocket maximum. Out-of-network amounts accumulate to the in-network, out-of-pocket maximum.	$3,000 individual $6,000 family Only the family limit above applies to a family plan.	$6,000 individual $12,000 per family Only the family limit above applies to a family plan.
Common Accident Deductible: If two or more members of the same family are injured in a common accident, only one deductible amount, if applicable, will be applied.		

Your Benefits	In network	Out of network
Ambulance services	Subject to deductible and coinsurance	Subject to in network deductible and coinsurance
Anesthesia services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Chiropractic Services		
• **Office Visit**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Therapies, manipulations, and X-rays**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Durable medical equipment and medical supplies (Including insulin pump and supplies)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hearing examinations (diagnostic)	Subject to deductible and coinsurance	Subject to deductible and coinsurance

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Your Benefits	In network	Out of network
Home health care • **Limited to 40 visits per calendar year.** • **Additional 40 visits available if terminally ill (hospice).**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hospice care	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hospital emergency room services		
• **Emergency room facility**	Subject to deductible and coinsurance	Subject to in network deductible and coinsurance
• **Other emergency room services**	Subject to deductible and coinsurance	Subject to in network deductible and coinsurance
Hospital inpatient services • **Precertification required** (Including semi-private or special care room, operating room, ancillary services and supplies)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hospital outpatient and surgical center services (Not including emergency room)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Maternity services		
• **Hospital services**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Physician services**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Mental health and substance abuse services		
• **Inpatient care** (Pre-certification required)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Outpatient office visit**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Transitional care**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Testing and evaluation**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Office Visit	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Outpatient laboratory Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Outpatient radiology Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Your Benefits	**In network**	**Out of network**

Outpatient therapy services (Pre-certification required after 15 visits. Refer to the SPD for specific limitations.)		
• **Medical Biofeedback** (As part of an approved pain management program)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Occupational therapy**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Physical therapy**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Speech therapy**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Physician services		
• **Hospital services**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Other services in an office**	Subject to deductible and coinsurance (Preventive immunizations covered at 100%)	Subject to deductible and coinsurance
Preventive benefit		
• **Comprehensive physical examination** (complete physical) ~ Well-baby care ~ Well-child care ~ Adolescent well-care ~ Adult well-care	Covered at 100%	Covered at 100%
• **Gynecological examination for women** (breast exam and pelvic exam)	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
• **Digital prostate examination for men**	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
• **Mammogram to screen for breast cancer**	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance

Your Benefits	In network	Out of network
• **Pap smear to screen for cervical cancer**	1 per calendar year then subject to	1 per calendar year then

	deductible and coinsurance	subject to deductible and coinsurance
• **Colonoscopy screening for colorectal cancer**	1 every two years then subject to deductible and coinsurance	1 per two years then subject to deductible and coinsurance
• **Other screenings for colorectal cancer** ~ Sigmoidoscopy ~ Double contrast barium enema ~ Fecal occult blood testing	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
• **Screening laboratory services** Including, but are not limited to: basic metabolic panel, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), prostate specific antigen (PSA), and urinalysis.	Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance	Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance
• **Bone mineral density (dexa scan) to screen for osteoporosis in women**	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
• **Chlamydia screening for women**	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
• **Ultrasound for screen of an abdominal aortic aneurysm for men**	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
• **Immunizations and vaccinations** (including those needed for travel)	Covered at 100%	Covered at 100%
Skilled nursing facility • **Limited to 107 days per calendar year**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Surgical services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Temporomandibular joint disorders or TMJ nonsurgical treatment	Subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Transplant services	Subject to deductible and coinsurance	Subject to deductible and coinsurance

Vision examinations (diagnostic)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
All other covered	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Wellness Benefit The following routine services are covered up to the $600 maximum per participant and no further benefits are available for the remainder of the calendar year:		
• **Health Fitness Organizations** (Must attend 8 sessions per month)	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
• **Routine Dental Care** (Limited to 2 exams and 1 X-ray. Teeth cleaning with fluoride. Sealants for children under 15.)	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
• **Smoking Cessation** (Must attend 80% of sessions per month.)	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
• **Sports Physical**	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
• **Routine vision exam and refraction including frames and lenses**	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
• **Routine hearing care including hearing checks**	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
• **Weight Loss Programs** (Must attend 80% of sessions per month.)	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit

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Precertification Required **Contact Hines and Associates at 800.483.5984 or www.precertcare.com**

• All Inpatient hospitalizations
• Skilled Nursing Facility and Residential Stays
• Transplants
• Physical, Occupational, and Speech therapy after 15 visits per calendar year
• Second Surgical Opinions
• Outpatient surgery including:
  ○ Abdominoplasty
  ○ Carpel Tunnel Release
  ○ Cosmetic/Reconstructive Surgery
  ○ Hip Replacement
  ○ Infuse Bone Graft
  ○ Knee Replacement
  ○ Panniculectomy
  ○ Port Wine Stain – Abnormal Vascular Lesion Treatment
  ○ Reduction Mammoplasty
  ○ Rhinoplasty
  ○ Septoplasty
  ○ Spinal Cord Stimulator

Pharmacy	
Prescriptions that are available in generic must be received in generic or the insured will pay the difference in the cost between the generic and name brand. The difference will not apply towards the prescription out of pocket. **Limited to a 90 day supply for both retail and mail order.** **New members as of 1/1/16 forward must receive prior authorization on certain medications.** **New members as of 1/1/16 forward will be required to follow step therapy requirements on certain medications.** **The use of a specialty pharmacy may be required for select medications, as indicated in the Formulary Guide.** **Refer to the SPD for specific limitations.**	Subject to deductible and coinsurance. 100% coverage for Preventive Drugs (not subject to deductible). Please refer to the Preventive Medication List for a list of covered products. More information about your prescription drug plan is available at www.sastpa.com or call 1-800-570-8760.