Schedule of Benefits - Active Advantage Indemnity

Group 670011 - MARSHFIELD CLINIC HEALTH SYSTEMS
Benefit Year: April 1st through March 31st
Effective Date: 04/01/2018

Security Administrative Services

Security Administrative Services certifies that you and any covered dependents have coverage as described in your Summary Plan Description 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 plan allows you to seek care from network (sometimes referred to as affiliated) providers as well as non-network providers. The plan reimburses services from network and non-network providers differently. This Schedule shows your specific cost-sharing, as well as any additional benefits, limitations or exclusions not shown in your Summary Plan Description. 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 Summary Plan Description for details about your coverage.** Benefits are calculated according to the benefit year shown above.

Your Responsibilities	
Deductible	$1,300 per individual $2,600 per family
Coinsurance	20% of the next $6,000 per individual $12,000 per family
Emergency room facility copayment (Waived if admitted to the hospital as an inpatient)	$200 copayment per visit Balance of charge after copayment applies to annual deductible and coinsurance. Copayments continue after deductible and coinsurance have been satisfied.
Annual out-of-pocket (Deductible, coinsurance & copayments)	$6,550 per individual $13,100 per family

Your Benefits	
Ambulance services	Subject to deductible and coinsurance
Anesthesia services	Subject to deductible and coinsurance
Care my way (Marshfield Clinic Health System service)	Covered at 100% (3 visits per individual per year covered at 100% before deductible and coinsurance is applied)
Chiropractic services	Subject to deductible and coinsurance
Durable medical equipment and medical supplies (Including insulin pump and supplies)	Subject to deductible and coinsurance

Your Benefits	
Chronic care management	
• **Asthma care management**	• Office visits with your asthma care provider are limited to 4 visits per individual per benefit year then subject to deductible and coinsurance • Unlimited spirometry services • Unlimited asthma care kits • Unlimited peak flow meters • Unlimited spacers • Asthma medications identified on the asthma medications list for members in the asthma disease management program are covered at 100%
• **Diabetes care management**	• Office visits with your diabetes care provider are limited to 4 visits per individual per benefit year then subject to deductible and coinsurance • Unlimited services for diabetes outpatient self-management education • Medical nutrition therapy services are limited to 4 visits with a registered dietician per individual per benefit year (refer to Summary Plan Description) • Vision examinations are limited to 1 examination per individual per benefit year • The following lab services are covered 100% when accompanied with a diabetes diagnosis: urine albumin/microalbumin, urine protein, urinalysis, hemoglobin A1C, lipid panel, lipoprotein and/or triglycerides
• **High cholesterol care management**	• The following lab services are covered 100%: lipid panel, lipoprotein or triglycerides
Hearing examinations	Subject to deductible and coinsurance
Home health care	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	
• **Emergency room facility** (Copayment waived if admitted to hospital as inpatient)	$200 copayment per visit Balance of charge after copayment applies to annual deductible and coinsurance. Copayments continue after deductible and coinsurance have been satisfied.
• **Other 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

Your Benefits	
Hospital outpatient and surgical center services (Not including emergency room)	Subject to deductible and coinsurance
Maternity services	
• **Hospital services**	Subject to deductible and coinsurance
• **Physician services**	Subject to deductible and coinsurance
Mental health services	
• **Inpatient care**	Subject to deductible and coinsurance
• **Outpatient care**	6 days covered at 100% per calendar year then subject to deductible and coinsurance
• **Transitional care**	6 days covered at 100% per calendar year then subject to deductible and coinsurance
Office visits	Subject to deductible and coinsurance 2 primary care physician office visits per individual per year covered at 100% before deductible and coinsurance are applied.
Outpatient laboratory services	Subject to deductible and coinsurance
Outpatient radiology services	Subject to deductible and coinsurance
Outpatient therapy services	
• **Occupational therapy**	Subject to deductible and coinsurance
• **Physical therapy**	Subject to deductible and coinsurance
• **Speech therapy**	Subject to deductible and coinsurance
Physician services	
• **Hospital services**	Subject to deductible and coinsurance
• **Other services in an office**	Subject to deductible and coinsurance

Your Benefits	
Preventive benefit Please refer to Security Administrative Services Preventive Service Guidelines at www.securityhealth.org/preventive for service frequency recommendations.	
• **Comprehensive physical examination** (complete physical) ~ Well-baby care ~ Well-child care ~ Adolescent well-care visits ~ Adult well-care visits ~ Screening for interpersonal and domestic violence ~ Counseling for sexually transmitted infections	Covered at 100%
• **Gynecological examination** (breast exam and pelvic exam)	1 per calendar year then subject to deductible and coinsurance
• **Digital prostate examination**	1 per calendar year then subject to deductible and coinsurance
• **Preventive hearing test**	1 per calendar year then subject to deductible and coinsurance
• **Comprehensive preventive vision examination**	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
• **Pap smear to screen for cervical cancer**	1 per calendar year then subject to deductible and coinsurance
• **Colonoscopy screening for colorectal cancer**	1 every 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
• **Screening laboratory services** Including, but are not limited to: basic metabolic panel, BRCA (1 & 2) testing, breast cancer genetic testing, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), pediatric lead poisoning screening, prostate specific antigen (PSA), and urinalysis.	Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance
• **Bone mineral density (dexa scan) to screen for osteoporosis**	1 per calendar year then subject to deductible and coinsurance
• **Chlamydia screening**	1 per calendar year then subject to deductible and coinsurance

Your Benefits	
• **Ultrasound for screening of an abdominal aortic aneurysm**	1 per calendar year then subject to deductible and coinsurance
• **Breast feeding support and counseling**	Covered at 100%
• **Immunizations and vaccinations** (including those needed for travel)	Covered at 100%
Skilled nursing facility	Subject to deductible and coinsurance (Limited to 30 days per individual per confinement)
Substance abuse services	
• **Inpatient care**	Subject to deductible and coinsurance
• **Outpatient care**	6 days covered at 100% per calendar year then subject to deductible and coinsurance
• **Transitional care**	15 days covered at 100% per calendar year then subject to deductible and coinsurance
Surgical services	Subject to deductible and coinsurance
Temporomandibular joint disorders or TMJ non-surgical treatment	Subject to deductible and coinsurance (Limited to 4 physical/occupational visits for diagnosis of TMJ per year)
Transplant services	Subject to deductible and coinsurance
Vision examinations	Subject to deductible and coinsurance

Pharmacy	
• Up to 30 days worth of medication constitutes a 1-month supply. For most maintenance medications 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 (at any Marshfield Clinic Pharmacy location) may supply maintenance medications in a 90-day supply and if applicable 2 1/2 copayments and/or coinsurance and/or deductible will be assessed. • 100% coverage for tier 1 and tier 2 oral anti-diabetic medications. (Not subject to deductible, if applicable.) • 100% coverage for tier 1 and tier 2 insulin and diabetic testing supplies. (Not subject to deductible, if applicable.) • Diabetic medications, testing supplies and insulin not listed on tier 1 or tier 2 of the Formulary Guide will require medical exception review from the Security Health Plan Pharmacy Services Department. (This does not include insulin pumps and related supplies. Please refer to the durable medical equipment section of the Schedule of Benefits for coverage.) • 100% coverage for generic hypertension medications when filled at any Marshfield Clinic Pharmacy location. • 100% coverage for Asthma medications when filled at any Marshfield Clinic Pharmacy location. Please refer to the Active Advantage asthma medications list for a list of covered products. • 100% coverage for smoking cessation products, limited to 90 days per benefit year, as indicated in the Formulary Guide. An additional 90 days may be approved if member completes the Tobacco Free program offered by Security Health Plan. • Over-the-counter (OTC) medications are generally excluded; however, coverage may be provided for selected OTC medications with a prescription authorization, as indicated in the Formulary Guide. • Specialty medications, as indicated in the formulary guide, must be filled at any Marshfield Clinic Pharmacy location.	The following benefit applies when filled at any MARSHFIELD CLINIC PHARMACY location: $5 copayment per tier 1 prescription or refill. $30 copayment per tier 2 prescription or refill. $60 copayment per tier 3 prescription or refill. 25% coinsurance per TIER 4 prescription or refill (specialty meds). Members may receive a one-time fill (up to a 30-day supply) of each maintenance medication at pharmacies other than Marshfield Clinic. Quantities beyond the 30-day supply will be required to be filled at any Marshfield Clinic Pharmacy or through the mail from a Marshfield Clinic Pharmacy. Maintenance drugs obtained at a non-Marshfield Clinic Pharmacy will not be approved after members have received a 30-day supply, and you will be responsible for the full cost of the drug. The following benefit applies when filled at any NON-MARSHFIELD CLINIC PHARMACY location: $10 copayment per tier 1 prescription or refill. $50 copayment per tier 2 prescription or refill. Tier 3 drugs-member pays the greater of $100 or 50% of the cost of prescriptions. No coverage for tier 4 prescriptions (specialty medications) unless filled at any Marshfield Clinic Pharmacy location. For limited distribution drugs which are only available through select pharmacies, 25% coinsurance will be assessed. If the participant requests the brand name product for a medication 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 product and the generic product. The ancillary charge will not count towards the prescription out-of-pocket limit. Deductible, copayments and coinsurance may apply to the max out of pocket amounts. Benefit year - April 1st thru March 31st

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 Summary Plan Description 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 Summary Plan Description.

Prior Authorization

The following services require you to obtain prior authorization before receiving the service. Your health care provider can start the prior authorization process by downloading a printable Prior Authorization Form at www.securityhealth.org/priorauthorization or contact us at 1-800-548-1224.

Medical Services

- Abdominoplasty
- Air ambulance transport
- Amino Acid Formula
- Autologous Cultured Chondrocytes
- Cardiac valve replacement
- Clinical trials
- Cosmetic and reconstructive surgery
- Elective inpatient Admission including medical (acute and behavioral health) and surgical
- Enteral feeding
- Experimental or investigational services
- Fecal transplant
- Femoro-acetabular surgery for hip impingement syndrome
- Gender reassignment
- Genetic testing
- Home health including but not limited to skilled nursing, physical therapy, occupational therapy, speech therapy
- Hospice
- Infuse bone graft
- Lung volume reduction surgery
- MAZE
- Non-affiliate provider request
- Non-emergent ambulance transport
- Office procedure with site of service request other than in an office setting
- Outpatient procedure with site of service request as inpatient setting
- Outpatient therapy treatment (occupational therapy, physical therapy, speech therapy)
- Second opinion
- Skin substitutes
- Spinal cord stimulation
- Swing bed admission
- Transplants
- TMJ
- Elective outpatient procedures such as, but not limited to: carpal tunnel surgery, knee arthroscopy, back surgeries at all levels

Prior Authorization

Medical Pharmacy

The following services require you to obtain prior authorization before receiving the service. Your health care provider can start the prior authorization process by accessing the information at: www.securityhealth.org or contact us at 1-800-548-1224.

- Amino acid-based infant formula
- Antiemetic-CINV
- Bone resorption Inhibitors
- Botulinum toxins
- C1 Esterase inhibitors
- Chemotherapy protectant
- Corticotropin
- Ecallantide (KalbitorB.)
- Hematopoietic agents
- Hyaluronan or derivatives
- Immune globulins
- Immunosuppressants
- Interleukin-5 Antagonists
- Leuprolide acetate depot
- Macular degeneration
- Monoclonal antibodies
- Octreotide depot
- Oncology-chemotherapy
- Pegloticase (KrystexxaB.)

Home Infusions

- Antibiotic/Antifungal
- Blood products
- Immune Globulins
- Oncology-chemotherapy
- Parenteral Nutrition

This list of medication classes is not all inclusive. Members and providers are encouraged to review the *S*ecurity Health Plan website at www.securityhealth.org or contact us at 1-800-548-1224 for the most recent updates.

Durable Medical Equipment

For most durable medical equipment (DME), you will need to work with your provider to receive prior authorization from Northwood at 1-866-532-1344.

Skilled Nursing Facility Services

For the skilled nursing facility services listed, you will need to work with your provider to notify NaviHealth at 1-855-512-7002 (Fax 1-855-847-7243).

- Acute rehabilitation admission
- Long term acute care admission
- Skilled nursing facilities admission

High-end imaging / Radiation oncology

For all high-end imaging and radiation oncology services, you will need to work with your provider to receive prior authorization from eviCore healthcare.

For high-end imaging
- www.medsolutionsonline.com
- Phone 1-888-693-3211
- Fax an eviCore request form (available online) to 1-888-693-3210

For radiation oncology
- www.carecorenational.com
- Phone 1-888-444-6185

Statement of Nondiscrimination

Security Administrative Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Limited English Proficiency Services

ATENCION: Si habla espanol, tiene a su disposicion servicios gratuitos de asistencia linguistica. 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).