Schedule of Benefits - HDHP Point of Service

Group 670019 - MARSHFIELD CLINIC HEALTH SYSTEM-MCHS
Benefit Year: April 1st through March 31st
Effective Date: 04/01/2019

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 Schedule shows your specific cost-sharing, as well as any additional benefits, and some plan limitations or exclusions. 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 unless otherwise noted.

Security Administrative Services pays non-network providers based on our Usual, Customary and Reasonable (UCR) fee schedule, subject to applicable deductible, coinsurance and copayment amounts. If a charge exceeds our reasonable and customary fee limit, we may reimburse less than the billed charge and the member is responsible for any amount charged in excess of such fees, as well as applicable deductible, coinsurance and copayment amounts. Any amount not covered by the UCR fee schedule and paid by the member does not count toward the maximum out-of-pocket limit for the plan.

Your Responsibilities	In network	Out of network
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.	$3,000 per individual $6,000 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.	$6,000 per individual $12,000 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	Covered services paid at 100% after deductible.	20% of the next $10,000 per individual $20,000 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. Copayments continue after deductible has been satisfied.	$200 copayment per visit Balance of charge after copayment applies to in network annual deductible. Copayments continue after deductible has been satisfied.
Annual out of pocket (Deductible, coinsurance & copayments) Out-of-network amounts accumulate to the in-and-out-of-network, out-of-pocket maximum.	$5,000 per individual $10,000 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.	$10,000 per individual $20,000 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.

Your Benefits	In network	Out of network
Ambulance services	Subject to deductible	Subject to in network deductible and coinsurance
Anesthesia services	Subject to deductible	Subject to deductible and coinsurance
Chiropractic services	Subject to deductible	Subject to deductible and coinsurance
Durable medical equipment and medical supplies (Including insulin pump and supplies)	Subject to deductible	Subject to deductible and coinsurance
Hearing examinations	Subject to deductible	Subject to deductible and coinsurance
Home health care	Subject to deductible (Limited to 40 visits per individual per calendar year)	Subject to deductible and coinsurance (Limited to 40 visits per individual per calendar year)
Hospice care	Subject to deductible	Subject to deductible and coinsurance
Hospital and 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. Copayments continue after deductible has been satisfied.	$200 copayment per visit Balance of charge after copayment applies to in network annual deductible. Copayments continue after deductible has been satisfied.
• **Other emergency room services**	Subject to deductible	Subject to in network deductible and coinsurance
Hospital inpatient services (Including semi-private or special care room, operating room, ancillary services and supplies)	Subject to deductible	Subject to deductible and coinsurance
Hospital outpatient and surgical center services (Not including emergency room)	Subject to deductible	Subject to deductible and coinsurance
Maternity services		
• **Hospital services**	Subject to deductible	Subject to deductible and coinsurance
• **Physician services**	Subject to deductible	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Mental health and substance abuse services		
• **Inpatient care**	Subject to deductible	Subject to deductible and coinsurance
• **Outpatient care**	Subject to deductible	Subject to deductible and coinsurance
• **Transitional care**	Subject to deductible	Subject to deductible and coinsurance
Office visits	Subject to deductible (Preventive exams covered at 100%)	Subject to deductible and coinsurance
Outpatient laboratory services	Subject to deductible	Subject to deductible and coinsurance
Outpatient radiology services	Subject to deductible	Subject to deductible and coinsurance
Outpatient therapy services		
• **Occupational therapy**	Subject to deductible	Subject to deductible and coinsurance
• **Physical therapy**	Subject to deductible	Subject to deductible and coinsurance
• **Speech therapy**	Subject to deductible	Subject to deductible and coinsurance
Physician services		
• **Hospital services**	Subject to deductible	Subject to deductible and coinsurance
• **Other services in an office**	Subject to deductible (Preventive immunizations covered at 100%)	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Preventive benefit Please refer to Security Health Plan's 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 ~ Adult well-care	Covered at 100%	Subject to deductible and coinsurance
• **Gynecological examination** (breast exam and pelvic exam)	1 per calendar year then subject to deductible	Subject to deductible and coinsurance
• **Digital prostate examination**	1 per calendar year then subject to deductible	Subject to deductible and coinsurance
• **Preventive hearing test**	1 per calendar year then subject to deductible	Subject to deductible and coinsurance
• **Comprehensive preventive vision examination**	1 per calendar year then subject to deductible	Subject to deductible and coinsurance
• **Mammogram to screen for breast cancer**	1 per calendar year then subject to deductible	Subject to deductible and coinsurance
• **Pap smear to screen for cervical cancer**	1 per calendar year then subject to deductible	Subject to deductible and coinsurance
• **Colonoscopy screening for colorectal cancer**	1 every two years then subject to deductible	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	Subject to deductible and coinsurance
• **Screening laboratory services** Including, but are not limited to: basic metabolic panel, 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	Subject to deductible and coinsurance
• **Bone mineral density (dexa scan) to screen for osteoporosis**	1 per calendar year then subject to deductible	Subject to deductible and coinsurance
• **Chlamydia screening**	1 per calendar year then subject to deductible	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
• **Ultrasound for screen of an abdominal aortic aneurysm**	1 per calendar year then subject to deductible	Subject to deductible and coinsurance
• **Breast feeding support and counseling**	Covered at 100%	Subject to deductible and coinsurance
• **Immunizations and vaccinations** (including those needed for travel)	Covered at 100%	Subject to deductible and coinsurance
Skilled nursing facility	Subject to deductible (Limited to 30 days per individual per confinement)	Subject to deductible and coinsurance (Limited to 30 days per individual per confinement)
Surgical services	Subject to deductible	Subject to deductible and coinsurance
Temporomandibular joint disorders or TMJ non-surgical treatment	Subject to deductible	Subject to deductible and coinsurance
Transplant services	Subject to deductible	Subject to deductible and coinsurance
Vision examinations	Subject to deductible	Subject to deductible and coinsurance

Pharmacy	
• 100% coverage for preventive prescription drugs (not subject to deductible, if applicable) when filled at any Marshfield Clinic Pharmacy location. 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. • Pharmacy mail service (at any Marshfield Clinic Pharmacy location) may supply maintenance prescription drugs in a 90-day supply and if applicable, 2 1/2 copayments and/or coinsurance will be assessed after deductible is met. • 100% coverage for tier 1 and tier 2 oral anti-diabetic prescription drugs. (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.)	Subject to the $3,000 individual deductible and $6,000 family deductible per year. After deductible, the following copayments apply to covered prescription drugs on next $2,000 per individual and $4,000 per family. 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 prescription drugs).

Pharmacy	
• Diabetic prescription drugs, 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 smoking cessation products, limited to 90 days per 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) drugs are generally excluded; however, after deductible, coverage may be provided for selected OTC drugs with a prescription authorization, as indicated in the Formulary Guide. • Specialty prescription drugs, as indicated in the formulary guide, must be filled at any Marshfield Clinic Pharmacy location.	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 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. 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. For medical pharmacy please check Security Health Plan's website for the full prior authorization list and for further information on prior authorization requests. 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
- Clinical trials
- Cosmetic and reconstructive surgery
- Elective inpatient Admission including medical (acute and behavioral health) and surgical
- Enteral feeding
- Fecal transplant
- Gender reassignment
- Genetic testing
- Home health including but not limited to skilled nursing, physical therapy, occupational therapy, speech therapy
- Hospice
- Infuse bone graft
- Intrastromal corneal ring segments
- Lung volume reduction surgery
- 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)
- Spinal cord stimulation
- Swing bed admission
- Technologies not commonly accepted as standard of care
- Transplants
- Elective outpatient procedures such as, but not limited to: carpal tunnel surgery, knee arthroscopy, back surgeries at all levels

Medical Pharmacy

- Antiemetics
- Antineoplastics
- Anti-migraine agents
- Biological Response Modifiers
- Bone resorption Inhibitors
- Botulinum toxin
- C1 Esterase Inhibitors
- Colony Stimulating factors
- Enzyme replacement therapy

Prior Authorization Cont.

Medical Pharmacy Cont.

- Hormone modifiers
- Hyaluronic acid
- Immunoglobulins
- Immunosuppressives
- Intravenous Immunoglobulin - Subcutaneous Immunoglobulin Infusion
- Intravitreal macular degeneration agents
- Parathyroid hormones
- Prostaglandins
- Respiratory agents
- Synagis
- Non-preferred iron products

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, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

Limited English Proficiency 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).

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).