SecurityHealth Plan℠
Security Administrative Services

Marshfield Clinic Health Systems
Group Numbers: 100648
Effective Date: April 1, 2021
Benefit Year: April 1 – March 31
Non-Grandfathered Plan

# POS HDHP Alliance Plan Schedule of Benefits

Security Administrative Services, LLC certifies that you and any covered dependents have coverage as described in your Summary Plan Document 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 plan.

This Schedule shows your specific cost-sharing, as well as any additional benefits, some 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, LLC 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.

**Network Tier 1** ~ The Alliance Premier Network (Marshfield Clinic Health System & UW Hospitals and Clinics Providers)
**Network Tier 2** ~ Other Alliance Network Providers
**Network Tier 3** ~ Out of Network / Wrap Network Providers

Tier 2 and Tier 3 amounts accumulate to the Tier 1 out-of-pocket maximum. Tier 1 amounts do not accumulate to the Tier 2 and Tier 3 out-of-pocket maximum.

| Your Responsibilities | Tier 1 The Alliance Premier | Tier 2 Other Network Providers | Tier 3 Out of Network Providers |
|---|---|---|---|
| **Deductible**<br>*Embedded deductible | $2,800 individual<br>$5,600 family | $3,500 individual<br>$7,000 family | $5,000 individual<br>$10,000 family |
| **Coinsurance** | 0% | 20% of the next<br>$10,000 per individual<br>$20,000 per family | 40% of the<br>$5,000 per individual<br>$10,000 per family |
| **Emergency room facility copayment**<br>Waived if admitted to the hospital as inpatient<br><br>Copayments continue after deductible has been satisfied. | $200 copayment per visit, balance subject to deductible | $200 copayment per visit, balance subject to Tier 1 deductible | $200 copayment per visit, balance subject to Tier 1 deductible |
| **Annual out-of-pocket**<br>**Embedded out-of-pocket<br><br>Deductible, coinsurance, and copays (includes pharmacy charges). | $4,000 individual<br>$8,000 family | $7,000 individual<br>$14,000 family | $9,000 individual<br>$18,000 family |

*Embedded deductible: 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.

**Embedded out of pocket: 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.

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.

| Your Benefits | Tier 1 The Alliance Premier | Tier 2 Other Network Providers | Tier 3 Out of Network Providers |
|---|---|---|---|
| **Ambulance services** | Subject to deductible | Subject to Tier 1 deductible | Subject to Tier 1 deductible |
| **Anesthesia services** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Care My Way**<br>Telephonic service available at 1-800-549-3174 | Covered at 100% | Not applicable | Not applicable |
| **Chiropractic services** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Diabetes care management**<br>• Unlimited services for diabetes outpatient self-management education<br>• Medical nutrition therapy services are limited to 4 visits with a registered dietician per individual per benefit year<br>• Hemoglobin A1c - one additional lab per calendar year at 100% (Tier 1 Network Only) | Covered at 100% | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Dry needling**<br>Limited to 20 visits per individual per calendar year | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Durable medical equipment and medical supplies**<br>Including insulin pump and supplies | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |

| Your Benefits | Tier 1 The Alliance Premier | Tier 2 Other Network Providers | Tier 3 Non-Network Providers |
|---|---|---|---|
| **Habilitative services**<br>• **Occupational therapy** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **Physical therapy** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **Speech therapy** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Hearing examinations (diagnostic)** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Home health care**<br>Limited to 40 visits per individual per calendar year | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Hospice care** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Hospital emergency room services**<br>• **Emergency room facility**<br>Copayment waived if admitted to hospital as inpatient<br>Copayments continue after deductible has been satisfied | $200 copayment per visit, balance subject to deductible | $200 copayment per visit, balance subject to Tier 1 deductible | $200 copayment per visit, balance subject to Tier 1 deductible |
| • **Physician visit** | Subject to deductible | Subject to Tier 1 deductible | Subject to Tier 1 deductible |
| • **Other emergency room services** | Subject to deductible | Subject to Tier 1 deductible | Subject to Tier 1 deductible |
| **Hospital inpatient services**<br>Including semi-private or special care room, operating room, ancillary services and supplies | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Hospital outpatient and surgical center services**<br>Not including emergency room | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |

| Your Benefits | Tier 1 The Alliance Premier | Tier 2 Other Network Providers | Tier 3 Non-Network Providers |
|---|---|---|---|
| **Infusion therapy** | | | |
| • **Outpatient services** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **Home infusion services** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Maternity services** | | | |
| • **Hospital services** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **Physician services** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **Breast pump** | Covered at 100% | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **Gestational diabetes treatment** | Covered at 100% | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **Breast feeding support, supplies, counseling** | Covered at 100% | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Mental health and substance use disorder services** | | | |
| • **Inpatient care**<br>Including semi-private room and ancillary services | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **Outpatient care** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **Transitional care** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Nutritional counseling**<br>Limited to 4 visits per individual per calendar year | Covered at 100% | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Office visit** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |

| Your Benefits | Tier 1 The Alliance Premier | Tier 2 Other Network Providers | Tier 3 Non-Network Providers |
|---|---|---|---|
| **Outpatient laboratory services** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Outpatient radiology services** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Physician services**<br>• **Hospital / Surgical center services**<br>Not including emergency room | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **Other services in an office** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Preventive benefit**<br>Please refer to Security Health Plan's Preventive Service Guidelines at www.securityhealth.org/preventive for service frequency recommendations and a list of screening laboratory services or contact us at 1-877-509-1952<br>• **Comprehensive physical examination**<br>Well-baby care<br>Well-child care<br>Adolescent well-care<br>Adult well-care<br>Screening for interpersonal and domestic violence<br>Counseling for sexually transmitted infections | Covered at 100% | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **Gynecological examination**<br>Breast exam and pelvic exam | 1 per calendar year then subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **Digital prostate examination** | 1 per calendar year then subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **Preventive hearing test** | 1 per calendar year then subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **Comprehensive preventive vision examination** | 1 per calendar year then subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |

| Your Benefits | Tier 1 The Alliance Premier | Tier 2 Other Network Providers | Tier 3 Non-Network Providers |
|---|---|---|---|
| **Preventive benefit cont.** | | | |
| • **Mammogram to screen for breast cancer**<br>Includes 3D mammogram | 1 per calendar year then subject to deductible | Subject to deductible and coinsurance | 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 | Subject to deductible and coinsurance |
| • **Colonoscopy screening for colorectal cancer**<br>*Age 50+ | 1 every five years* (every two years with personal / family history) then subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **Sigmoidoscopy screening for colorectal cancer**<br>*Age 50+ | 1 every five years* (every two years with personal / family history) then subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **Other screenings for colorectal cancer**<br>Fecal occult blood testing | 1 per calendar year then subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **Screening laboratory services**<br>Including, but are not limited to BRCA (1 & 2) testing*, breast cancer genetic testing*, general health panel, lipoprotein, lipid panel, glucose (blood sugar) and pediatric lead poisoning screening<br>*Prior authorization required | Each laboratory service covered at 1 per calendar year then subject to deductible | Subject to deductible and coinsurance | 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 | Subject to deductible and coinsurance |
| • **Chlamydia screening** | 1 per calendar year then subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **HPV Screening / counseling** | 1 per calendar year then subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **Ultrasound to screen for an abdominal aortic aneurysm** | 1 per calendar year then subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |

| Your Benefits | Tier 1 The Alliance Premier | Tier 2 Other Network Providers | Tier 3 Non-Network Providers |
|---|---|---|---|
| **Preventive benefit cont.**<br>• **Immunizations and vaccinations**<br>Including those needed for travel | Covered at 100% | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Rehabilitative therapy**<br>• **Occupational therapy** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **Physical therapy** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| • **Speech therapy** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Skilled nursing facility**<br>Limited to 30 days per confinement | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Temporomandibular joint disorders or TMJ nonsurgical treatment**<br>Limited to 4 physical/occupational visits for diagnosis of TMJ per year | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Transplant services** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **Vision examinations (diagnostic)** | Subject to deductible | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| **All other covered** | Subject to deductible | Subject to deductible and coinsurance | 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, including Marshfield Medical Center – Beaver Dam Pharmacy. Please refer to the Preventive Medication List for a list of covered products.<br><br>• Up to 30 days worth of prescription drugs constitutes a 1-month supply.<br><br>• Pharmacy mail service (at any Marshfield Clinic Pharmacy / Marshfield Medical Center – Beaver Dam 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.<br><br>• 100% coverage for oral anti-diabetic prescription drugs included on the Preventive Medication list (Not subject to deductible, if applicable.<br><br>• 100% coverage for insulin and diabetic testing supplies included on the Preventive Medication list (Not subject to deductible, if applicable.)<br><br>• Diabetic prescription drugs, testing supplies and insulin not included on the Preventive Medication list 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.)<br><br>• 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.<br><br>• Specialty prescription drugs, as indicated in the formulary guide, must be filled at any Marshfield Clinic Pharmacy / Marshfield Medical Center – Beaver Dam Pharmacy location. | Subject to the $2,800 individual deductible and $5,600 family deductible per year. After deductible, the following copayments and/or coinsurance apply to covered prescription drugs until the max out-of-pocket is met.<br><br>The following benefit applies when filled at any MARSHFIELD CLINIC PHARMACY including MARSHFIELD MEDICAL CENTER – BEAVER DAM PHARMACY:<br><br>• $5 copayment per tier 1 prescription or refill.<br>• $30 copayment per tier 2 prescription or refill.<br>• $60 copayment per tier 3 prescription or refill.<br>• 25% coinsurance per tier 4 prescription or refill (specialty prescription drugs).<br><br>Members may receive a one-time fill (up to a 30-day supply) of each maintenance medication at pharmacies other than Marshfield Clinic Pharmacy / Marshfield Medical Center – Beaver Dam Pharmacy. Quantities beyond the 30-day supply will be required to be filled at any Marshfield Clinic Pharmacy / Marshfield Medical Center – Beaver Dam Pharmacy. Maintenance drugs obtained at a **non**-Marshfield Clinic Pharmacy / Marshfield Medical Center – Beaver Dam 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.<br><br>The following benefit applies when filled at any **NON** MARSHFIELD CLINIC PHARMACY / MARSHFIELD MEDICAL CENTER – BEAVER DAM PHARMACY:<br><br>• $10 copayment per tier 1 prescription or refill.<br>• $50 copayment per tier 2 prescription or refill.<br>• Tier 3 drugs-member pays the greater of $100 or 50% of the cost of prescriptions.<br>• No coverage for tier 4 prescriptions (specialty medications) unless filled at any Marshfield Clinic Pharmacy / Marshfield Medical Center – Beaver Dam Pharmacy location. For limited distribution drugs which are only available through select pharmacies, 25% coinsurance will be assessed.<br><br>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. |

**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 1-877-509-1952.

**Medical Services**

- Abdominoplasty
- Air ambulance transport
- Amino Acid Formula
- Autologous Cultured Chondrocytes
- Cardiac catheterization for elective and outpatient procedures
- Clinical trials
- Cosmetic and reconstructive surgery
- Elective inpatient Admission including medical (acute and behavioral health) and surgical
- Elective outpatient procedures such as, but not limited to: carpal tunnel surgery, knee arthroscopy, back surgeries at all levels.
- Electroconvulsive therapy (after 10 visits)
- Enteral feeding
- 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
- Infuse bone graft
- Non-emergent ambulance transport
- 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
- Technologies not commonly accepted as standard of care
- Transplants
- TMJ
- Vagus nerve stimulator

This list of medical services is not all-inclusive. The most up-to-date medical services list requiring prior authorizations can be found on our website at www.securityhealth.org/authorization. You can also call our Customer Service Department at 1-877-509-1952 to find out what medical services require prior authorization.

**Medical Benefit Drugs**

Medical benefit drugs may require prior authorization. The most up-to-date medical benefit drug list can be found on our website at www.securityhealth.org/SpecialtyRx. Medical benefit drugs may be added or removed from this list quarterly on a calendar year basis. You can also call our Customer Service Department at 1-877-509-1952 to find out what medical benefit drugs require prior authorization. For medical benefit drug prior authorization, you will need to work with your provider to notify Magellan at 1-800-424-8243.

**Prior Authorization Cont.**

**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.

The most up-to-date eligible durable medical equipment list can be found on our website at www.securityhealth.org/DME. You can also call our Customer Service Department at 1-877-509-1952 to find out what durable medical equipment is on the eligible list.

**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, including by not limited to CT scans, PET scans, MRAs and MRIs, you will need to work with your provider to receive prior authorization from eviCore healthcare.

For high-end imaging
- www.evicore.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

**Home Infusion**
Home infusion drugs may require prior authorization. The most up to date Home Infusion drug list can be found on our website at www.securityhealth.org/homeinfusion. Home infusion drugs may be added or removed from this list quarterly on a calendar year basis. You can also call our Customer Service Department at 1-877-509-1952 to find out what medical benefit drugs require prior authorization for home infusion.

**Statement of Nondiscrimination**

Security Administrative Service, LLC, 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.

| **Limited English Proficiency Services** |
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| 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).<br><br>ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-472-2363 (TTY: 711).<br><br>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). |