MARSHFIELD CLINIC HEALTH SYSTEM, INC.
HEALTH PLAN

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
AMENDMENT #1 TO MASTER PLAN DOCUMENT
EFFECTIVE: April 1, 2019

Marshfield Clinic Health System, Inc. Health Plan ("the Plan") Plan Document and Summary Plan Description ("Plan Document") are hereby amended as follows:

The section entitled Definitions, the following is removed:

"Other Plan"
"Other Plan" shall include, but is not limited to:

1. Any primary payer besides the Plan.
2. Any other group health plan.
3. Any other coverage or policy covering the Participant.
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
5. Any policy of insurance from any insurance company or guarantor of a responsible party.
6. Any policy of insurance from any insurance company or guarantor of a third party.
7. Workers' compensation or other liability insurance company.
8. Any other source, including but not limited to crime victim restitution funds, any medical, or other benefit payments, and school insurance coverage.

And replaced with:

"Other Plan"
"Other Plan" shall include, but is not limited to:

1. Any primary payer besides the Plan.
2. Any other group health plan.
3. Any other coverage or policy covering the Participant, excluding vision or dental only coverage.
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
5. Any policy of insurance from any insurance company or guarantor of a responsible party.
6. Any policy of insurance from any insurance company or guarantor of a third party.
7. Workers' compensation or other liability insurance company.
8. Any other source, including but not limited to crime victim restitution funds, any medical, or other benefit payments, and school accident-type coverage.

The section entitled Coordination of Benefits, the following is removed:

Excess Insurance
If at the time of Injury, Sickness, death or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment of law or settlement), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible, any of the following:

1. Any primary payer besides the Plan.
2. Any policy of insurance from any insurance company or guarantor of a third party.
3. Workers' compensation insurance.
4. Any other source, including but not limited to medical or other benefit payments, and school insurance coverage.

And replaced with:

Excess Insurance
If at the time of Injury, Sickness, death or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment of law or settlement), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible, any of the following:

1. Any primary payer besides the Plan.
2. Any policy of insurance from any insurance company or guarantor of a third party.
3. Workers' compensation insurance.
4. Any other source, including but not limited to medical or other benefit payments, excluding school accident-type coverage.

The section entitled Coordination of Benefits, the following is removed:

Order of Benefit Determination
For the purposes of the provision entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan.
2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent.
3. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
    a. When the parents were never married, are separated, or are divorced, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
    b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

    Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the child as a dependent child.
4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

5. To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

And replaced with:

Order of Benefit Determination
For the purposes of the provision entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan.
2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent.
3. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
    a. When the parents were never married, are separated, or are divorced, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
    b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

   Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the child as a dependent child.
4. If an individual is covered under one plan as an active employee (or dependent of an active employee), and is also covered under another plan as a retired or laid-off employee (or dependent of a retired or laid-off employee), the plan that covers the person as an active employee (or dependent of any active employee) will be primary. If the other plan does not have this rule, this rule is ignored.
5. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.
6. To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

The section entitled Third Party Recovery, Subrogation and Reimbursement, the following is removed:

Subrogation
As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
If the Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

And replaced with:

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
If the Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, or other benefit payments, excluding school accident-type coverage.

The section entitled Third Party Recovery, Subrogation and Reimbursement, the following is removed:

Other Insurance

If at the time of Injury, Sickness, death or disability there is available, or potentially available any other source of Coverage (including but not limited to Coverage resulting from a judgment of law or settlement), the benefits under this Plan shall apply only after such other sources of Coverage have been exhausted..

The Plan's benefits will be payable after, whenever possible, any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

And replaced with:

Other Insurance
If at the time of Injury, Sickness, death or disability there is available, or potentially available any other source of Coverage (including but not limited to Coverage resulting from a judgment of law or settlement), the benefits under this Plan shall apply only after such other sources of Coverage have been exhausted..

The Plan's benefits will be payable after, whenever possible, any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, or other benefit payments, excluding school accident-type coverage.

The section entitled Medical Benefits – Exclusions, the following is added:

Removal of skin tags.

The section entitled Summary of Benefits, the schedules of benefits have been completely removed and replaced with:

Summary of Benefits – Medical (Active Advantage)
The following benefits are per Participant per Plan Year. All benefits are subject to the Maximum Allowable Charge, applicable deductible, coinsurance and copayment amounts. If a charge exceeds the Maximum Allowable Charge, the Plan may reimburse less than the billed charge and the Participant 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 Plan and paid by the Participant does not count toward the maximum out-of-pocket limit for the plan.

Your Responsibilities	In network	Out of network
Deductible	$1,300 per individual $2,600 per family	$2,600 per individual $5,200 per family
Coinsurance	20% of the next $6,000 per individual $12,000 per family	40% 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.	$200 copayment per visit Balance of charge after copayment applies to annual in network deductible and coinsurance. Copayments continue after deductible and coinsurance have 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.	$6,550 per individual $13,100 per family	$13,100 per individual $26,200 per family

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	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

Your Benefits	In network	Out of network
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%	Subject to deductible and coinsurance
• **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	Subject to deductible and coinsurance
• **High cholesterol care management**	• The following lab services are covered 100%: lipid panel, lipoprotein or triglycerides	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Hearing examinations	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Home health care	Subject to deductible and coinsurance (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 and coinsurance	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.	$200 copayment per visit Balance of charge after copayment applies to annual in network deductible and coinsurance. Copayments continue after deductible and coinsurance have been satisfied.
• **Other emergency room services**	Subject to deductible and coinsurance	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 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 services		
• **Inpatient care**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Outpatient care**	6 days covered at 100% per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Transitional care**	6 days covered at 100% per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
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.	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
Outpatient therapy services		
• **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

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 and coinsurance	Subject to deductible and coinsurance
• **Digital prostate examination**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Preventive hearing test**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Comprehensive preventive vision examination**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Mammogram to screen for breast cancer**	1 per calendar year then 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 and coinsurance	Subject to deductible and coinsurance
• **Colonoscopy screening for colorectal cancer**	1 every two years then subject to deductible and coinsurance	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	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 and coinsurance	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
• **Bone mineral density (dexa scan) to screen for osteoporosis**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Chlamydia screening**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Ultrasound for screen of an abdominal aortic aneurysm**	1 per calendar year then subject to deductible and coinsurance	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 and coinsurance (Limited to 30 days per individual per confinement)	Subject to deductible and coinsurance (Limited to 30 days per individual per confinement)
Substance abuse services		
• **Inpatient care**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Outpatient care**	6 days covered at 100% per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Transitional care**	15 days covered at 100% per calendar year then 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 non-surgical treatment	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Transplant services	Subject to deductible and coinsurance	Not covered
Vision examinations	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 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 and/or deductible will be assessed. • 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.) • 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, 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.	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 prescription drugs). 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

Summary of Benefits – Medical (Active Advantage Indemnity)

The following benefits are per Participant per Plan Year. All benefits are subject to the Maximum Allowable Charge, applicable deductible, coinsurance and copayment amounts. If a charge exceeds the Maximum Allowable Charge, the Plan may reimburse less than the billed charge and the Participant 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 Plan and paid by the Participant does not count toward the maximum out-of-pocket limit for the plan.

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
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 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%
• **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, 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
• **Ultrasound for screen of an abdominal aortic aneurysm**	1 per calendar year then subject to deductible and coinsurance

Your Benefits	
• **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
Transplant services	Subject to deductible and coinsurance
Vision examinations	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 and/or deductible will be assessed. • 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.) • 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, 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.	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 prescription drugs). 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

Summary of Benefits – Medical (HDHP Point of Service)

The following benefits are per Participant per Plan Year. All benefits are subject to the Maximum Allowable Charge, applicable deductible, coinsurance and copayment amounts. If a charge exceeds the Maximum Allowable Charge, the Plan may reimburse less than the billed charge and the Participant 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 Plan and paid by the Participant 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

Summary of Benefits – Medical (HDHP Indemnity)

The following benefits are per Participant per Plan Year. All benefits are subject to the Maximum Allowable Charge, applicable deductible, coinsurance and copayment amounts. If a charge exceeds the Maximum Allowable Charge, the Plan may reimburse less than the billed charge and the Participant 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 Plan and paid by the Participant does not count toward the maximum out-of-pocket limit for the plan.

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.	$3,000 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.
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.
Annual out of pocket (Deductible & copayments)	$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.

Your Benefits	
Ambulance services	Subject to deductible
Anesthesia services	Subject to deductible
Chiropractic services	Subject to deductible
Durable medical equipment and medical supplies (Including insulin pump and supplies)	Subject to deductible
Hearing examinations	Subject to deductible
Home health care	Subject to deductible (Limited to 40 visits per individual per calendar year)
Hospice care	Subject to deductible

Your Benefits	
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.
Other emergency room services	Subject to deductible
Hospital inpatient services (Including semi-private or special care room, operating room, ancillary services and supplies)	Subject to deductible
Hospital outpatient and surgical center services (Not including emergency room)	Subject to deductible
Maternity services	
Hospital services	Subject to deductible
Physician services	Subject to deductible
Mental health and substance abuse services	
Inpatient care	Subject to deductible
Outpatient care	Subject to deductible
Transitional care	Subject to deductible
Office visits	Subject to deductible (Preventive exams covered at 100%)
Outpatient laboratory services	Subject to deductible
Outpatient radiology services	Subject to deductible
Outpatient therapy services	
Occupational therapy	Subject to deductible
Physical therapy	Subject to deductible
Speech therapy	Subject to deductible
Physician services	
Hospital services	Subject to deductible
Other services in an office	Subject to deductible (Preventive immunizations covered at 100%)

Your Benefits	
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%
Gynecological examination (breast exam and pelvic exam)	1 per calendar year then subject to deductible
Digital prostate examination	1 per calendar year then subject to deductible
Preventive hearing test	1 per calendar year then subject to deductible
Comprehensive preventive vision examination	1 per calendar year then subject to deductible
Mammogram to screen for breast cancer	1 per calendar year then subject to deductible
Pap smear to screen for cervical cancer	1 per calendar year then subject to deductible
Colonoscopy screening for colorectal cancer	1 every two years then subject to deductible
Other screenings for colorectal cancer ~ Sigmoidoscopy ~ Double contrast barium enema ~ Fecal occult blood testing	1 per calendar year then subject to deductible
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
Bone mineral density (dexa scan) to screen for osteoporosis	1 per calendar year then subject to deductible
Chlamydia screening	1 per calendar year then subject to deductible
Ultrasound for screen of an abdominal aortic aneurysm	1 per calendar year then subject to deductible
Breast feeding support and counseling	Covered at 100%
Immunizations and vaccinations (including those needed for travel)	Covered at 100%

Your Benefits	
Skilled nursing facility	Subject to deductible (Limited to 30 days per individual per confinement)
Surgical services	Subject to deductible
Temporomandibular joint disorders or TMJ non-surgical treatment	Subject to deductible
Transplant services	Subject to deductible
Vision examinations	Subject to deductible

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.) 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.	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). 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.

Pharmacy	
	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

All other provisions of the Master Plan Document shall remain the same.

Marshfield Clinic Health System, Inc.

By: Marion Pfaff

Name: MARION PFAFF

Title: Chief Human Resources Officer

Date: 9/16/19