MARSHFIELD CLINIC HEALTH SYSTEM, INC.
HEALTH PLAN

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
AMENDMENT #3 TO MASTER PLAN DOCUMENT
EFFECTIVE: April 1, 2020

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:

"Dependent"
"Dependent" shall mean one or more of the following person(s):

1. An Employee's present spouse, thereby possessing a valid marriage license, not annulled or voided in any way. A Dependent spouse shall therefore not be one whom is divorced from the Employee.
2. An Employee's Child who is less than 26 years of age. ***NOTE:*** *Coverage of a Dependent Child will continue until the end of the calendar month he or she turns 26 years of age.*
3. An Employee's Child, regardless of age, who was continuously covered prior to attaining the limiting age as stated in the numbers above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age as stated in the numbers above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age as stated in the numbers above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.

Active duty members of any armed force shall not be deemed to be "Dependents."

Residents of a country other than the United States shall not be deemed to be "Dependents."

To establish a Dependent relationship, the Plan reserves the right to require documentation satisfactory to the Plan Administrator.

And replaced with:

"Dependent"
"Dependent" shall mean one or more of the following person(s):

1. An Employee's present spouse, thereby possessing a valid marriage license, not annulled or voided in any way. A Dependent spouse shall therefore not be one who is divorced or Legally separated from the Employee.
2. An Employee's opposite-sex domestic partner who is at least 18 years old, unmarried nor in a domestic partnership with another person, has met the requirements of and submitted the Declaration of Domestic Partnership to the Plan. ***NOTE:*** *To the extent COBRA coverage is applicable, an Employee's domestic partner is not considered a qualified beneficiary and does not have independent rights under COBRA; however, an Employee's domestic partner will be entitled to COBRA continuation coverage as a dependent of a qualified beneficiary. An Employee's domestic partner will be considered a qualified beneficiary and eligible to continue coverage under the COBRA provisions to the same extent as an Employee's spouse.*
3. An Employee's same-sex domestic partner who is at least 18 years old, unmarried nor in a domestic partnership with another person, has met the requirements of and submitted the

Declaration of Domestic Partnership to the Plan. ***NOTE:*** *To the extent COBRA coverage is applicable, an Employee's domestic partner is not considered a qualified beneficiary and does not have independent rights under COBRA; however, an Employee's domestic partner will be entitled to COBRA continuation coverage as a dependent of a qualified beneficiary. An Employee's domestic partner will be considered a qualified beneficiary and eligible to continue coverage under the COBRA provisions to the same extent as an Employee's spouse.*

4. An Employee's Child or spouse's child who is less than 26 years of age. ***NOTE:*** *Coverage of a Dependent Child will continue until the end of the calendar month he or she turns 26 years of age.*
5. An Employee's Child or spouse's child, regardless of age, who was continuously covered prior to attaining the limiting age as stated in the numbers above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age as stated in the numbers above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age as stated in the numbers above. The time limit for written proof of incapacity and dependency is 31 days following the original eligibility date for a new or re-enrolling Employee. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.

Active duty members of any armed force shall not be deemed to be "Dependents."

Residents of a country other than the United States shall not be deemed to be "Dependents."

To establish a Dependent relationship, the Plan reserves the right to require documentation satisfactory to the Plan Administrator.

NOTE: Tax treatment for certain dependents. *Federal tax law generally does not recognize former spouses, Legally Separated spouses, civil union or domestic partners, or the children of these partners, as dependents under the federal tax code unless the spouse, partner, or child otherwise qualifies as a dependent under the Internal Revenue Code §152. Therefore, the Employer may be required to automatically include the value of the health care coverage provided to any of the aforementioned individuals, who may be covered under this Plan as eligible Dependents, as additional income to the Employee*

The section entitled Eligibility for Coverage, the following is removed:

Special and Open Enrollment

Federal law requires and the Plan provides so-called "Special Enrollment Periods," during which Employees may enroll in the Plan, even if they declined to enroll during an initial or subsequent eligibility period. The Special Enrollment rules are described in more detail within the Eligibility for Coverage section.

Loss of Other Coverage

This Plan will permit an eligible Employee or Dependent (including his or her spouse) who is eligible, but not enrolled, to enroll for coverage under the terms of the Plan if each of the following conditions is met:

1. The eligible Employee or Dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered.
2. The eligible Employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to the eligible Employee having coverage under another group health plan or due to the Employee having other health insurance coverage.
3. The eligible Employee or Dependent lost other coverage pursuant to one of the following events:
    a. The eligible Employee or Dependent was under COBRA and the COBRA coverage was exhausted.
    b. The eligible Employee or Dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of Legal Separation, divorce,

loss of Dependent status, death, termination of employment, or reduction in the number of hours worked).

c. The eligible Employee or Dependent moved out of an HMO service area with no other option available.
d. The Plan is no longer offering benefits to a class of similarly situated individuals.
e. The benefit package option is no longer being offered and no substitute is available.
f. The Employer contributions were terminated.

If an Employee is currently enrolled in a benefit package, the Employee may elect to enroll in another benefit package under the Plan if the following requirements are met:

1. Multiple benefit packages are available.
2. A Dependent of the enrolled Employee has a special enrollment right in the Plan because the Dependent has lost eligibility for other coverage.

Special enrollment rights will not be available to an Employee or Dependent if either of the following occurs:

1. The other coverage is/was available via COBRA Continuation Coverage and the Employee or Dependent failed to exhaust the maximum time available to him or her for such COBRA coverage.
2. The Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Other Plan).

For an eligible Employee or Dependent(s) who has met the conditions specified above, this Plan will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written or electronic request for enrollment (including the Participant's enrollment application, either paper or electronic as applicable, in the case of enrollment) is received by the Plan and the request is made within 31 days from loss of coverage. For example, if the Employee loses his or her other health coverage on April 22, he or she must notify the Plan Administrator and apply for coverage by close of business on May 23.

New Dependent

An Employee or Dependent who is eligible, but not enrolled in this Plan, may be eligible to enroll during a special enrollment period if an Employee acquires a new Dependent as a result of marriage, legal guardianship, birth, adoption, or placement for adoption. To be eligible for this special enrollment, the Employee must apply in writing or electronically, as applicable, no later than 31 days after he or she acquires the new Dependent. For example, if the Employee or Employee's spouse gives birth to a baby on June 22, he or she must notify the Plan Administrator and apply for coverage by close of business on July 23. The following conditions apply to any eligible Employee and Dependents:

An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll during a special enrollment period if one of the following occurs:

1. The eligible Employee is a covered Employee under the terms of this Plan but elected not to enroll during a previous enrollment period.
2. An individual has become a Dependent of the eligible Employee through marriage, legal guardianship, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied, the coverage of the Dependent and/or Employee enrolled during the Special Enrollment Period will be effective at 12:01 A.M. for the following events:

1. In the case of marriage, on the date of the marriage.
2. For a legal guardianship, on the date on which such Child is placed in the covered Employee's home pursuant to a court order appointing the covered Employee as legal guardian for the Child.
3. In the case of a Dependent's birth, as of the date of birth.
4. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Additional Special Enrollment Rights

Employees and Dependents who are eligible but not enrolled are entitled to enroll under one of the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination.
2. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written or electronic request, as applicable, (including the Participant's enrollment application, either paper or electronic as applicable, in the case of enrollment) is received by the Plan.

And replaced with:

Special and Open Enrollment

Federal law requires and the Plan provides so-called "Special Enrollment Periods," during which Employees may enroll in the Plan, even if they declined to enroll during an initial or subsequent eligibility period.

Loss of Other Coverage

This Plan will permit an eligible Employee or Dependent (including his or her spouse or domestic partner) who is eligible, but not enrolled, to enroll for coverage under the terms of the Plan if each of the following conditions is met:

1. The eligible Employee or Dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered.
2. The eligible Employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to the eligible Employee having coverage under another group health plan or due to the Employee having other health insurance coverage.
3. The eligible Employee or Dependent lost other coverage pursuant to one of the following events:
    a. The eligible Employee or Dependent was under COBRA and the COBRA coverage was exhausted.
    b. The eligible Employee or Dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of Legal Separation, divorce, loss of Dependent status, death, termination of employment, or reduction in the number of hours worked).
    c. The eligible Employee or Dependent moved out of an HMO service area with no other option available.
    d. The Plan is no longer offering benefits to a class of similarly situated individuals.
    e. The benefit package option is no longer being offered and no substitute is available.
    f. The Employer contributions were terminated.

If an Employee is currently enrolled in a benefit package, the Employee may elect to enroll in another benefit package under the Plan if the following requirements are met:

1. Multiple benefit packages are available.
2. A Dependent of the enrolled Employee has a special enrollment right in the Plan because the Dependent has lost eligibility for other coverage.

Special enrollment rights will not be available to an Employee or Dependent if either of the following requirements is met:

1. The other coverage is/was available via COBRA Continuation Coverage and the Employee or Dependent failed to exhaust the maximum time available to him or her for such COBRA coverage; or

2. The Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Other Plan).

For an eligible Employee or Dependent(s) who has met the conditions specified above, this Plan will be effective at 12:01 A.M. on the first day following the loss of other coverage and the request is made within 31 days from loss of coverage. For example, if the Employee loses his or her other health coverage on April 22, he or she must notify the Plan Administrator and apply for coverage by close of business on May 23.

New Dependent

An Employee or Dependent who is eligible, but not enrolled in this Plan, may be eligible to enroll during a special enrollment period if an Employee acquires a new Dependent as a result of marriage, domestic partnership, legal guardianship, birth, adoption, or placement for adoption. To be eligible for this special enrollment, the Employee must apply in writing or electronically, as applicable, no later than 31 days after he or she acquires the new Dependent. For example, if the Employee or Employee's spouse gives birth to a baby on June 22, he or she must notify the Plan Administrator and apply for coverage by close of business on July 23. The following conditions apply to any eligible Employee and Dependents:

An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll during a special enrollment period if both of the following conditions are met:

1. The eligible Employee is a covered Employee under the terms of this Plan but elected not to enroll during a previous enrollment period.
2. An individual has become a Dependent of the eligible Employee through marriage, domestic partnership, legal guardianship, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied, the coverage of the Dependent and/or Employee enrolled during the Special Enrollment Period will be effective at 12:01 A.M. for the following events:

1. In the case of marriage, on the date of the marriage.
2. For a domestic partnership, on the date of the domestic partnership agreement.
3. For a legal guardianship, on the date on which such Child is placed in the covered Employee's home pursuant to a court order appointing the covered Employee as legal guardian for the Child.
4. In the case of a Dependent's birth, as of the date of birth.
5. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Additional Special Enrollment Rights

Employees and Dependents who are eligible but not enrolled are entitled to enroll under one of the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination.
2. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day.

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

Marshfield Clinic Health Systems
Active Advantage Indemnity Schedule of Benefits

Security Administrative Services, LLC 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. This plan allows you to seek care from network (sometimes referred to as affiliated) providers as well as non-network providers.

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.

Your Responsibilities	
Deductible	$1,300 individual $2,600 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 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, copays	$6,550 individual $13,100 family

Your Benefits	
Ambulance services	Subject to deductible and coinsurance
Anesthesia services	Subject to deductible and coinsurance
Care My Way	Covered at 100%
Chiropractic Services	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
Durable medical equipment and medical supplies Including insulin pump and supplies	Subject to deductible and coinsurance
Hearing examinations (diagnostic)	Subject to deductible and coinsurance
Home health care Limited to 40 visits per calendar year	Subject to deductible and coinsurance
Hospice care	Subject to deductible and coinsurance
Hospital emergency room services • **Emergency room facility** Balance of charge after copayment applies to annual deductible and coinsurance. Copayments continue after deductible and coinsurance have been satisfied.	Subject $200 copayment then deductible and coinsurance
• **Other emergency room services**	Subject to deductible and coinsurance
Hospital inpatient services Includes 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 and newborn services • **Hospital services** • **Physician services** • **Breast feeding support, supplies, counseling** • **Breast Pump** • **Gestational Diabetes treatment**	 Subject to deductible and coinsurance Subject to deductible and coinsurance Covered at 100% Covered at 100% Covered at 100%
Mental health and substance abuse services • **Inpatient care** • **Outpatient care** • **Transitional care**	 Subject to deductible and coinsurance 6 days covered at 100% per calendar year (when criteria is met) then subject to deductible and coinsurance 6 days covered at 100% per calendar year for mental health (when criteria is met) then subject to deductible and coinsurance. 15 days covered at 100% per calendar year for substance abuse (when criteria is met) then subject to deductible and coinsurance
Nutritional Counseling Limited to 4 visits per calendar year	Subject to deductible and coinsurance
Office visit	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** • **Physical therapy** • **Speech therapy**	 Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance
Physician services • **Hospital services / surgery center** • **Other services in an office**	 Subject to deductible and coinsurance Subject to deductible and coinsurance

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

Your Benefits	
Preventive Benefit Cont. • **Chlamydia screening** • **HPV Screening / counseling** • **Ultrasound to screen for an abdominal aortic aneurysm** • **Immunizations and vaccinations** Including those needed for travel	 1 per calendar year then subject to deductible and coinsurance 1 per calendar year then subject to deductible and coinsurance 1 per calendar year then subject to deductible and coinsurance Covered at 100%
Skilled nursing facility Limited to 30 days per confinement	Subject to deductible and coinsurance
Temporomandibular joint disorders or TMJ nonsurgical treatment	Subject to deductible and coinsurance
Transplant services • **Dialysis** • **Organ procurement and acquisition** • **Transplant procedure**	 Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance
Vision examinations (diagnostic)	Subject to deductible and coinsurance
All other covered	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. • 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.	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.

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 1-800-570-8760.

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
- 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
- Interventional pain management services
- Non-emergent ambulance transport
- Non-network provider request
- Outpatient procedure with site of service request as inpatient setting
- Outpatient therapy treatment (occupational therapy, physical therapy, speech therapy)
- Second opinion
- Skin substitutes
- Sleep Study
- 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.

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.

Prior Authorization Cont.

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

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-877-509-1952 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-509-1952 (TTY: 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-509-1952 (TTY: 711).

Marshfield Clinic Health Systems
Active Advantage HMO Schedule of Benefits

Security Administrative Services, LLC 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. **NOTE: All services must be received from affiliated providers, except as otherwise described in the Summary Plan Description.**

Your Responsibilities	
Deductible	$1,300 individual $2,600 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 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, copays	$6,550 individual $13,100 family

Your Benefits	
Ambulance services	Subject to deductible and coinsurance
Anesthesia services	Subject to deductible and coinsurance
Care My Way	Covered at 100%
Chiropractic Services	Subject to deductible and coinsurance
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%

Your Benefits	
Chronic care management Cont. • **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
Durable medical equipment and medical supplies Including insulin pump and supplies	Subject to deductible and coinsurance
Hearing examinations (diagnostic)	Subject to deductible and coinsurance
Home health care Limited to 40 visits per calendar year	Subject to deductible and coinsurance
Hospice care	Subject to deductible and coinsurance
Hospital emergency room services • **Emergency room facility** Balance of charge after copayment applies to annual deductible and coinsurance. Copayments continue after deductible and coinsurance have been satisfied.	Subject $200 copayment then deductible and coinsurance
• **Other emergency room services**	Subject to deductible and coinsurance
Hospital inpatient services Includes semi-private or special care room, operating room, ancillary services and supplies	Subject to deductible and coinsurance
Hospital outpatient and surgical center services Not including emergency room	Subject to deductible and coinsurance
Maternity and newborn services • **Hospital services**	Subject to deductible and coinsurance
• **Physician services**	Subject to deductible and coinsurance
• **Breast feeding support, supplies, counseling**	Covered at 100%

Your Benefits	
Maternity and newborn services • **Breast Pump** • **Gestational Diabetes treatment**	 Covered at 100% Covered at 100%
Mental health and substance abuse services • **Inpatient care** • **Outpatient care** • **Transitional care**	 Subject to deductible and coinsurance 6 days covered at 100% per calendar year (when criteria is met) then subject to deductible and coinsurance 6 days covered at 100% per calendar year for mental health (when criteria is met) then subject to deductible and coinsurance. 15 days covered at 100% per calendar year for substance abuse (when criteria is met) then subject to deductible and coinsurance.
Nutritional Counseling Limited to 4 visits per calendar year	Subject to deductible and coinsurance
Office visit	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** • **Physical therapy** • **Speech therapy**	 Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance
Physician services • **Hospital services / surgery center** • **Other services in an office**	 Subject to deductible and coinsurance Subject to deductible and coinsurance
Preventive benefit Please refer to Security Administrative Services' Preventive Service Guidelines at www.securityhealth.org/preventive under Health Care Reform for service frequency recommendations. • **Comprehensive physical examination** Well-baby care Well-child care Adolescent well-care Adult well-care Screening for interpersonal and domestic violence Counseling for sexually transmitted infections	 Covered at 100%

Your Benefits	
Preventive Benefit Cont.	
• **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 five years then subject to deductible and coinsurance
• **Sigmoidoscopy screening for colorectal cancer**	1 every five years then subject to deductible and coinsurance
• **Other screenings for colorectal cancer** Fecal occult blood testing	1 per calendar year then subject to deductible and coinsurance
• **Screening laboratory services** Including, but are not limited to: basic metabolic panel, BRCA (1 & 2) testing, breast cancer genetic testing, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), pediatric lead poisoning screening, prostate specific antigen (PSA), and urinalysis.	Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance
• **Bone mineral density (dexa scan) to screen for osteoporosis**	1 per calendar year then subject to deductible and coinsurance
• **Chlamydia screening**	1 per calendar year then subject to deductible and coinsurance
• **HPV Screening / counseling**	1 per calendar year then subject to deductible and coinsurance
• **Ultrasound to screen for an abdominal aortic aneurysm**	1 per calendar year then subject to deductible and coinsurance
• **Immunizations and vaccinations** Including those needed for travel	Covered at 100%

Your Benefits	
Skilled nursing facility Limited to 30 days per confinement	Subject to deductible and coinsurance
Temporomandibular joint disorders or TMJ nonsurgical treatment	Subject to deductible and coinsurance
Transplant services • **Dialysis** • **Organ procurement and acquisition** • **Transplant procedure**	 Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance
Vision examinations (diagnostic)	Subject to deductible and coinsurance
All other covered	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. • 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.	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.

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 1-800-570-8760.

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
- 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
- Interventional pain management services
- Non-emergent ambulance transport
- Non-network provider request
- Outpatient procedure with site of service request as inpatient setting
- Outpatient therapy treatment (occupational therapy, physical therapy, speech therapy)
- Second opinion
- Skin substitutes
- Sleep Study
- 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.

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.

Prior Authorization Cont.

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

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-877-509-1952 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-509-1952 (TTY: 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-509-1952 (TTY: 711).

Marshfield Clinic Health Systems
Active Advantage POS Schedule of Benefits

Security Administrative Services, LLC 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, 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.

Your Responsibilities	In network	Out of network
Deductible	$1,300 individual $2,600 family	$2,600 individual $5,200 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 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 deductible and coinsurance. Copayments continue after deductible and coinsurance have been satisfied.
Annual out of pocket Deductible, coinsurance, copays Out-of-network amounts accumulate to the in-network, out-of-pocket maximum.	$6,550 individual $13,100 family	$13,100 individual $26,200 family

Your Benefits	In network	Out of network
Ambulance services	Subject to deductible and coinsurance	Subject to in-network deductible
Anesthesia services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Care My Way	Covered at 100%	N/A
Chiropractic Services	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
Durable medical equipment and medical supplies Including insulin pump and supplies	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hearing examinations (diagnostic)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Home health care Limited to 40 visits per calendar year	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hospice care	Subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Hospital emergency room services • **Emergency room facility** Balance of charge after copayment applies to annual deductible and coinsurance. Copayments continue after deductible and coinsurance have been satisfied.	Subject $200 copayment then deductible and coinsurance	Subject $200 copayment then in-network deductible and coinsurance
• **Other emergency room services**	Subject to deductible and coinsurance	Subject to in-network deductible and coinsurance
Hospital inpatient services Includes 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 and newborn 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
• **Breast feeding support, supplies, counseling**	Covered at 100%	Subject to deductible and coinsurance
• **Breast Pump**	Covered at 100%	Subject to deductible and coinsurance
• **Gestational Diabetes treatment**	Covered at 100%	Subject to deductible and coinsurance
Mental health and 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 (when criteria is met) then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Transitional care**	6 days covered at 100% per calendar year for mental health (when criteria is met) then subject to deductible and coinsurance. 15 days covered at 100% per calendar year for substance abuse (when criteria is met) then subject to deductible and coinsurance	Subject to deductible and coinsurance
Nutritional Counseling Limited to 4 visits per calendar year	Subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Office visit	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** • **Physical therapy** • **Speech therapy**	 Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance	 Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance
Physician services • **Hospital services / surgery center** • **Other services in an office**	 Subject to deductible and coinsurance Subject to deductible and coinsurance	 Subject to deductible and coinsurance Subject to deductible and coinsurance
Preventive benefit Please refer to Security Administrative Services' Preventive Service Guidelines at www.securityhealth.org/preventive under Health Care Reform for service frequency recommendations. • **Comprehensive physical examination** Well-baby care Well-child care Adolescent well-care Adult well-care Screening for interpersonal and domestic violence Counseling for sexually transmitted infections	 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

Your Benefits	In network	Out of network
Preventive Benefit Cont. • **Colonoscopy screening for colorectal cancer**	1 every five years then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Sigmoidoscopy screening for colorectal cancer**	1 every five years then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Other screenings for colorectal cancer** 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, BRCA (1 & 2) testing, breast cancer genetic testing, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), pediatric lead poisoning screening, prostate specific antigen (PSA), and urinalysis.	Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **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
• **HPV Screening / counseling**	1 per calendar year then 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 and coinsurance	Subject to deductible and coinsurance
• **Immunizations and vaccinations** Including those needed for travel	Covered at 100%	Subject to deductible and coinsurance
Skilled nursing facility Limited to 30 days per confinement	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Temporomandibular joint disorders or TMJ nonsurgical treatment	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Transplant services • **Dialysis**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Organ procurement and acquisition**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Transplant procedure**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Vision examinations (diagnostic)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
All other covered	Subject to deductible and coinsurance	Subject to deductible and coinsurance

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.. • 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.	The following 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.

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 1-800-570-8760.

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
- 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
- Interventional pain management services
- Non-emergent ambulance transport
- Non-network provider request
- Outpatient procedure with site of service request as inpatient setting
- Outpatient therapy treatment (occupational therapy, physical therapy, speech therapy)
- Second opinion
- Skin substitutes
- Sleep Study
- 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.

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.

Prior Authorization Cont.

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

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-877-509-1952 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-509-1952 (TTY: 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-509-1952 (TTY: 711).

Marshfield Clinic Health Systems
Active Advantage J1 VISA Schedule of Benefits

Security Administrative Services, LLC 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, 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.

Your Responsibilities	In network	Out of network
Deductible	$500 individual $1,000 family	$1,000 individual $2,000 family
Coinsurance	20% of the next $12,500 per individual $25,000 per family	40% of the next $12,500 per individual $25,000 per family
Emergency room facility copayment Waived if admitted to the 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 deductible and coinsurance. Copayments continue after deductible and coinsurance have been satisfied.
Annual out of pocket Deductible, coinsurance, copays Out-of-network amounts accumulate to the in-network, out-of-pocket maximum.	$6,550 individual $13,100 family	$13,100 individual $26,200 family

Your Benefits	In network	Out of network
Ambulance services	Subject to deductible and coinsurance	Subject to in-network deductible
Anesthesia services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Care My Way	Covered at 100%	N/A
Chiropractic Services	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
Durable medical equipment and medical supplies Including insulin pump and supplies	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hearing examinations (diagnostic)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Home health care Limited to 40 visits per calendar year	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hospice care	Subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Hospital emergency room services • **Emergency room facility** Balance of charge after copayment applies to annual deductible and coinsurance. Copayments continue after deductible and coinsurance have been satisfied.	Subject $200 copayment then deductible and coinsurance	Subject $200 copayment then in-network deductible and coinsurance
• **Other emergency room services**	Subject to deductible and coinsurance	Subject to in-network deductible and coinsurance
Hospital inpatient services Includes 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 and newborn 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
• **Breast feeding support, supplies, counseling**	Covered at 100%	Subject to deductible and coinsurance
• **Breast Pump**	Covered at 100%	Subject to deductible and coinsurance
• **Gestational Diabetes treatment**	Covered at 100%	Subject to deductible and coinsurance
Mental health and 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 (when criteria is met) then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Transitional care**	6 days covered at 100% per calendar year for mental health (when criteria is met) then subject to deductible and coinsurance. 15 days covered at 100% per calendar year for substance abuse (when criteria is met) then subject to deductible and coinsurance.	Subject to deductible and coinsurance
Nutritional Counseling Limited to 4 visits per calendar year	Subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Office visit	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** • **Physical therapy** • **Speech therapy**	 Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance	 Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance
Physician services • **Hospital services / surgery center** • **Other services in an office**	 Subject to deductible and coinsurance Subject to deductible and coinsurance	 Subject to deductible and coinsurance Subject to deductible and coinsurance
Preventive benefit Please refer to Security Administrative Services' Preventive Service Guidelines at www.securityhealth.org/preventive under Health Care Reform for service frequency recommendations. • **Comprehensive physical examination** Well-baby care Well-child care Adolescent well-care Adult well-care Screening for interpersonal and domestic violence Counseling for sexually transmitted infections • **Gynecological examination** Breast exam and pelvic exam • **Digital prostate examination** • **Preventive hearing test** • **Comprehensive preventive vision examination** • **Mammogram to screen for breast cancer** • **Pap smear to screen for cervical cancer**	 Covered at 100% 1 per calendar year then subject to deductible and coinsurance 1 per calendar year then subject to deductible and coinsurance 1 per calendar year then subject to deductible and coinsurance 1 per calendar year then subject to deductible and coinsurance 1 per calendar year then subject to deductible and coinsurance 1 per calendar year then subject to deductible and coinsurance	 Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Preventive Benefit Cont.		
• **Colonoscopy screening for colorectal cancer**	1 every five years then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Sigmoidoscopy screening for colorectal cancer**	1 every five years then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Other screenings for colorectal cancer** 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, BRCA (1 & 2) testing, breast cancer genetic testing, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), pediatric lead poisoning screening, prostate specific antigen (PSA), and urinalysis.	Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **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
• **HPV Screening / counseling**	1 per calendar year then 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 and coinsurance	Subject to deductible and coinsurance
• **Immunizations and vaccinations** Including those needed for travel	Covered at 100%	Subject to deductible and coinsurance
Skilled nursing facility Limited to 30 days per confinement	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Temporomandibular joint disorders or TMJ nonsurgical treatment	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Transplant services		
• **Dialysis**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Organ procurement and acquisition**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Transplant procedure**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Vision examinations (diagnostic)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
All other covered	Subject to deductible and coinsurance	Subject to deductible and coinsurance

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. • 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.	The following 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.

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 1-800-570-8760.

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
- 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
- Interventional pain management services
- Non-emergent ambulance transport
- Non-network provider request
- Outpatient procedure with site of service request as inpatient setting
- Outpatient therapy treatment (occupational therapy, physical therapy, speech therapy)
- Second opinion
- Skin substitutes
- Sleep Study
- 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.

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.

Prior Authorization Cont.

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

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-877-509-1952 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-509-1952 (TTY: 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-509-1952 (TTY: 711).

Marshfield Clinic Health Systems
HDHP Indemnity Schedule of Benefits

Security Administrative Services, LLC 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. This plan allows you to seek care from network (sometimes referred to as affiliated) providers as well as non-network providers

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.

Your Responsibilities	
Deductible	$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.
Coinsurance	0%
Emergency room facility copayment Waived if admitted to the hospital as 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, coinsurance, copays	$5,000 individual $10,000 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.
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	
Ambulance services	Subject to deductible
Anesthesia services	Subject to deductible

Your Benefits	
Care My Way	Covered at 100%
Chiropractic Services	Subject to deductible
Durable medical equipment and medical supplies Including insulin pump and supplies	Subject to deductible
Hearing examinations (diagnostic)	Subject to deductible
Home health care Limited to 40 visits per calendar year	Subject to deductible
Hospice care	Subject to deductible
Hospital emergency room services • **Emergency room facility** Balance of charge after copayment applies to annual deductible. Copayments continue after deductible has been satisfied. • **Other emergency room services**	Subject $200 copayment then deductible Subject to deductible
Hospital inpatient services Includes 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 and newborn services • **Hospital services** • **Physician services** • **Breast feeding support, supplies, counseling** • **Breast pump** • **Gestational diabetes treatment**	 Subject to deductible Subject to deductible Covered at 100% Covered at 100% Covered at 100%
Mental health and substance abuse services • **Inpatient care** • **Outpatient care** • **Transitional care**	 Subject to deductible Subject to deductible Subject to deductible
Nutritional counseling Limited to 4 visits per calendar year	Covered at 100%

Your Benefits	
Office visit	Subject to deductible
Outpatient laboratory Services	Subject to deductible
Outpatient radiology Services	Subject to deductible
Outpatient therapy services • **Occupational therapy** • **Physical therapy** • **Speech therapy**	 Subject to deductible Subject to deductible Subject to deductible
Physician services • **Hospital services / surgery center** • **Other services in an office**	 Subject to deductible Subject to deductible
Preventive benefit Please refer to Security Administrative Services' Preventive Service Guidelines at www.securityhealth.org/preventive under Health Care Reform for service frequency recommendations. • **Comprehensive physical examination** Well-baby care Well-child care Adolescent well-care Adult well-care Screening for interpersonal and domestic violence Counseling for sexually transmitted infections • **Gynecological examination** Breast exam and pelvic exam • **Digital prostate examination** • **Preventive hearing test** • **Comprehensive preventive vision examination** • **Mammogram to screen for breast cancer** • **Pap smear to screen for cervical cancer** • **Colonoscopy screening for colorectal cancer** • **Sigmoidoscopy screening for colorectal cancer**	 Covered at 100% 1 per calendar year then subject to deductible 1 per calendar year then subject to deductible 1 per calendar year then subject to deductible 1 per calendar year then subject to deductible 1 per calendar year then subject to deductible 1 per calendar year then subject to deductible 1 every five years then subject to deductible 1 every five years then subject to deductible

Your Benefits	
Preventive Benefit Cont. • **Other screenings for colorectal cancer** Fecal occult blood testing	1 per calendar year then subject to deductible
• **Screening laboratory services** Including, but are not limited to: basic metabolic panel, BRCA (1 & 2) testing, breast cancer genetic testing, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), pediatric lead poisoning screening, prostate specific antigen (PSA), and urinalysis.	Each laboratory service covered at 1 per calendar year then subject to deductible
• **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
• **HPV Screening**	1 per calendar year then subject to deductible
• **Ultrasound to screen for an abdominal aortic aneurysm**	1 per calendar year then subject to deductible
• **Immunizations and vaccinations** Including those needed for travel	Covered at 100%
Skilled nursing facility Limited to 30 days per confinement	Subject to deductible
Temporomandibular joint disorders or TMJ nonsurgical treatment	Subject to deductible
Transplant services • **Dialysis**	Subject to deductible
• **Organ procurement and acquisition**	Subject to deductible
• **Transplant procedure**	Subject to deductible
Vision examinations (diagnostic)	Subject to deductible
All other covered	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. • 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.

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
- 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
- Interventional pain management services
- Non-emergent ambulance transport
- Non-network provider request
- Outpatient procedure with site of service request as inpatient setting
- Outpatient therapy treatment (occupational therapy, physical therapy, speech therapy)
- Second opinion
- Skin substitutes
- Sleep Study
- 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.

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.

Prior Authorization Cont.

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

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-877-509-1952 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-509-1952 (TTY: 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-509-1952 (TTY: 711).

Marshfield Clinic Health Systems
HDHP HMO Schedule of Benefits

Security Administrative Services, LLC 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. **NOTE: All services must be received from affiliated providers, except as otherwise described in the Summary Plan Description.**

Your Responsibilities	
Deductible	$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.
Coinsurance	0%
Emergency room facility copayment Waived if admitted to the hospital as 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, coinsurance, copays	$5,000 individual $10,000 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.
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	
Ambulance services	Subject to deductible
Anesthesia services	Subject to deductible

Your Benefits	
Care My Way	Covered at 100%
Chiropractic Services	Subject to deductible
Durable medical equipment and medical supplies Including insulin pump and supplies	Subject to deductible
Hearing examinations (diagnostic)	Subject to deductible
Home health care Limited to 40 visits per calendar year	Subject to deductible
Hospice care	Subject to deductible
Hospital emergency room services • **Emergency room facility** Balance of charge after copayment applies to annual deductible. Copayments continue after deductible has been satisfied. • **Other emergency room services**	Subject $200 copayment then deductible Subject to deductible
Hospital inpatient services Includes 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 and newborn services • **Hospital services** • **Physician services** • **Breast feeding support, supplies, counseling** • **Breast pump** • **Gestational diabetes treatment**	 Subject to deductible Subject to deductible Covered at 100% Covered at 100% Covered at 100%
Mental health and substance abuse services • **Inpatient care** • **Outpatient care** • **Transitional care**	 Subject to deductible Subject to deductible Subject to deductible
Nutritional counseling Limited to 4 visits per calendar year	Covered at 100%

Your Benefits	
Office visit	Subject to deductible
Outpatient laboratory Services	Subject to deductible
Outpatient radiology Services	Subject to deductible
Outpatient therapy services • **Occupational therapy** • **Physical therapy** • **Speech therapy**	 Subject to deductible Subject to deductible Subject to deductible
Physician services • **Hospital services / surgery center** • **Other services in an office**	 Subject to deductible Subject to deductible
Preventive benefit Please refer to Security Administrative Services' Preventive Service Guidelines at www.securityhealth.org/preventive under Health Care Reform for service frequency recommendations. • **Comprehensive physical examination** Well-baby care Well-child care Adolescent well-care Adult well-care Screening for interpersonal and domestic violence Counseling for sexually transmitted infections • **Gynecological examination** Breast exam and pelvic exam • **Digital prostate examination** • **Preventive hearing test** • **Comprehensive preventive vision examination** • **Mammogram to screen for breast cancer** • **Pap smear to screen for cervical cancer** • **Colonoscopy screening for colorectal cancer** • **Sigmoidoscopy screening for colorectal cancer**	 Covered at 100% 1 per calendar year then subject to deductible 1 per calendar year then subject to deductible 1 per calendar year then subject to deductible 1 per calendar year then subject to deductible 1 per calendar year then subject to deductible 1 per calendar year then subject to deductible 1 every five years then subject to deductible 1 every five years then subject to deductible

Your Benefits	
Preventive Benefit Cont. • **Other screenings for colorectal cancer** Fecal occult blood testing	1 per calendar year then subject to deductible
• **Screening laboratory services** Including, but are not limited to: basic metabolic panel, BRCA (1 & 2) testing, breast cancer genetic testing, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), pediatric lead poisoning screening, prostate specific antigen (PSA), and urinalysis.	Each laboratory service covered at 1 per calendar year then subject to deductible
• **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
• **HPV Screening**	1 per calendar year then subject to deductible
• **Ultrasound to screen for an abdominal aortic aneurysm**	1 per calendar year then subject to deductible
• **Immunizations and vaccinations** Including those needed for travel	Covered at 100%
Skilled nursing facility Limited to 30 days per confinement	Subject to deductible
Temporomandibular joint disorders or TMJ nonsurgical treatment	Subject to deductible
Transplant services • **Dialysis**	Subject to deductible
• **Organ procurement and acquisition**	Subject to deductible
• **Transplant procedure**	Subject to deductible
Vision examinations (diagnostic)	Subject to deductible
All other covered	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. • 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.

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
- 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
- Interventional pain management services
- Non-emergent ambulance transport
- Non-network provider request
- Outpatient procedure with site of service request as inpatient setting
- Outpatient therapy treatment (occupational therapy, physical therapy, speech therapy)
- Second opinion
- Skin substitutes
- Sleep Study
- 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.

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.

Prior Authorization Cont.

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

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-877-509-1952 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-509-1952 (TTY: 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-509-1952 (TTY: 711).

Marshfield Clinic Health Systems
HDHP POS Schedule of Benefits

Security Administrative Services, LLC 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, 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.

Your Responsibilities	In network	Out of network
Deductible	$3,000 individual $6,000 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 individual $12,000 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	0%	20% of the next $10,000 per individual $20,000 per family
Emergency room facility copayment Waived if admitted to the 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.
Annual out of pocket Deductible, coinsurance, copays Out-of-network amounts accumulate to the in-network, out-of-pocket maximum.	$5,000 individual $10,000 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 individual $20,000 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.
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	In network	Out of network
Ambulance services	Subject to deductible	Subject to in-network deductible
Anesthesia services	Subject to deductible	Subject to deductible and coinsurance
Care My Way	Covered at 100%	N/A
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 (diagnostic)	Subject to deductible	Subject to deductible and coinsurance
Home health care Limited to 40 visits per calendar year	Subject to deductible	Subject to deductible and coinsurance
Hospice care	Subject to deductible	Subject to deductible and coinsurance
Hospital emergency room services • **Emergency room facility** Balance of charge after copayment applies to annual deductible. Copayments continue after deductible has been satisfied. • **Other emergency room services**	Subject $200 copayment then deductible Subject to deductible	Subject $200 copayment then in-network deductible Subject to in-network deductible
Hospital inpatient services Includes 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 and newborn services • **Hospital services** • **Physician services** • **Breast feeding support, supplies, counseling** • **Breast Pump** • **Gestational Diabetes treatment**	Subject to deductible Subject to deductible Covered at 100% Covered at 100% Covered at 100%	Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Mental health and substance abuse services • **Inpatient care** • **Outpatient care** • **Transitional care**	 Subject to deductible Subject to deductible Subject to deductible	 Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance
Nutritional Counseling Limited to 4 visits per calendar year	Subject to deductible	Subject to deductible and coinsurance
Office visit	Subject to deductible	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** • **Physical therapy** • **Speech therapy**	 Subject to deductible Subject to deductible Subject to deductible	 Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance
Physician services • **Hospital services / surgery center** • **Other services in an office**	 Subject to deductible Subject to deductible	 Subject to deductible and coinsurance Subject to deductible and coinsurance
Preventive benefit Please refer to Security Administrative Services' Preventive Service Guidelines at www.securityhealth.org/preventive under Health Care Reform for service frequency recommendations. • **Comprehensive physical examination** Well-baby care Well-child care Adolescent well-care Adult well-care Screening for interpersonal and domestic violence Counseling for sexually transmitted infections • **Gynecological examination** Breast exam and pelvic exam • **Digital prostate examination**	 Covered at 100% 1 per calendar year then subject to deductible 1 per calendar year then subject to deductible	 Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Preventive Benefit Cont.		
• **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 five years then subject to deductible	Subject to deductible and coinsurance
• **Sigmoidoscopy screening for colorectal cancer**	1 every five years then subject to deductible	Subject to deductible and coinsurance
• **Other screenings for colorectal cancer** 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, BRCA (1 & 2) testing, breast cancer genetic testing, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), pediatric lead poisoning screening, prostate specific antigen (PSA), and urinalysis.	Each laboratory service covered at 1 per calendar year then subject to deductible	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
• **HPV Screening / counseling**	1 per calendar year then subject to deductible	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
• **Immunizations and vaccinations** Including those needed for travel	Covered at 100%	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Skilled nursing facility Limited to 30 days per confinement	Subject to deductible	Subject to deductible and coinsurance
Temporomandibular joint disorders or TMJ nonsurgical treatment	Subject to deductible	Subject to deductible and coinsurance
Transplant services		
• **Dialysis**	Subject to deductible	Subject to deductible and coinsurance
• **Organ procurement and acquisition**	Subject to deductible	Subject to deductible and coinsurance
• **Transplant procedure**	Subject to deductible	Subject to deductible and coinsurance
Vision examinations (diagnostic)	Subject to deductible	Subject to deductible and coinsurance
All other covered	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.) • 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. • 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.

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 1-800-570-8760.

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
- 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
- Interventional pain management services
- Non-emergent ambulance transport
- Non-network provider request
- Outpatient procedure with site of service request as inpatient setting
- Outpatient therapy treatment (occupational therapy, physical therapy, speech therapy)
- Second opinion
- Skin substitutes
- Sleep Study
- 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.

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.

Prior Authorization Cont.

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

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-877-509-1952 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-509-1952 (TTY: 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-509-1952 (TTY: 711).

The section entitled Prescription Drug Benefits, the following is removed:

Covered Expenses

The following are covered under the Plan:

- A U.S. Food and Drug Administration-approved drug included on the current formulary. See our website at www.sastpa.com to view the most up-to-date formulary.
- A compounded drug that is not otherwise excluded under coverage and contains at least one FDA-approved prescription drug for which, in Security Administrative Services' determination, a commercially available alternative does not exist.
- Oral contraceptives for birth control when prescribed by a health care provider
- Maintenance drugs taken on a regular basis (typically daily) for a chronic medical condition. Most drugs will be available in maintenance quantities.
- Preventive drug coverage for select preventive drugs. The Preventive Drug List of drugs will be covered at a $0 copay. Prescriptions must be filled at a Marshfield Clinic Pharmacy to be eligible. The Preventive Drug List can be viewed on the website at: www.sastpa.com/Pharmacy-Benefit.
- The Cancer Treatment Fairness Act limits copayments to no more than $100 for a one-month supply of oral chemotherapy drugs. An ancillary charge will be assessed above and beyond the $100 monthly maximum for brand name drugs where a generic is available. For high deductible health plans, the copayment limit applies only after the deductible has been satisfied for the year. The ancillary charge is the cost difference between the brand name drug and the generic drug. The ancillary charge will not count towards the prescription out-of-pocket limit.

Limitations

The benefits set forth in this section will be limited to:

- A Marshfield Clinic pharmacy must be used for maintenance, preventive, and specialty drugs. Antibiotics and certain Schedule II controlled substances, including some drugs for the treatment of pain or attention deficit do not apply to a Marshfield Clinic Pharmacy mandate. You may obtain these from any affiliated pharmacy.
- If you are prescribed a drug and must fill it at a non-Marshfield Clinic pharmacy the higher copay will apply. Only a 30-day supply of a maintenance drug will be allowed to be filled one time during the year. After that you will have no coverage unless you transfer to a Marshfield Clinic Pharmacy.
- Specialty prescription drugs are required to be obtained at a designated specialty pharmacy with which Security Health Plan has an arrangement to provide these prescriptions.
- Specialty prescription drugs are limited to a one month supply.
- Select specialty prescription drugs that are known to be poorly tolerated will be limited to a number of partial fills to assess Participant tolerability and drug reaction prior to obtaining a one month fill.
- Security Administrative Services reserves the right to limit coverage of daily dosing regimens to FDA-approved dosing as defined by the manufacturer and clinical best-practice guidelines
- The formulary is reviewed and updated every month. Most changes involve adding new drugs or drugs that are newly available in generic form. At times, drugs are removed from the formulary, change tier, or moved to restricted status. Members and providers are encouraged to review the Security Administrative Services website at www.sastpa.com/Pharmacy-Benefit on a regular basis for the most recent updates.
- Members who receive multiple opioid-based drugs from several different prescribers and several different pharmacies may be required to use only one pharmacy for future opioid-based drugs.
- Coverage of opioid drugs for acute pain may be limited to a 7-day supply.
- All prescriptions should be submitted electronically using your Security Administrative Services pharmacy card. For prescriptions not submitted electronically, any dollar amounts in excess of the electronic contracted charge for that drug will not be covered.
- All claims not submitted electronically should be sent to Security Administrative Services within 90 days of date of service.
- Non-formulary drugs may be covered when an exception is requested by the health care provider. The request should include the member name; health care provider's name, address and telephone number; drug strength, dosage form and directions; diagnosis; lab medical data; and the medical reason for the request. Written requests should be sent to:

Security Administrative Services
ATTN: Pharmacy Services PO Box 8000
Marshfield, WI 54449-8000

Or email us at: shprx@securityhealth.org

Pharmacy Services can be reached at 1-877-873-5611

- Prescribed generic and brand-name drugs are subject to cost sharing. If either a covered brandname prescription drug, for which a generic equivalent is available, or a generic drug is prescribed, the prescription will be filled with the generic version. If you request the brand- name drug, you will be responsible for the cost-sharing that applies to the brand-name drug plus the cost difference between the brand name drug and the generic drug. The ancillary charge will not count towards the prescription out-of-pocket limit.
- Medical benefit drugs may require prior authorization, or preferred/alternative drugs to treat the same condition unless authorized by Security Administrative Services. Please refer to the Security Health Plan website at https://www.securityhealth.org/rxpa for the most up-to-date list of medical benefit drugs that require prior authorization.

And replaced with:

Covered Expenses

The following are covered under the Plan:

- A U.S. Food and Drug Administration-approved drug included on the current formulary. See our website at www.securityhealth.org/sas-prescriptiontools to view the most up-to-date formulary.
- A compounded drug that is not otherwise excluded under coverage and contains at least one FDA-approved prescription drug for which, in Security Administrative Services' determination, a commercially available alternative does not exist.
- Oral contraceptives for birth control when prescribed by a health care provider
- Maintenance drugs taken on a regular basis (typically daily) for a chronic medical condition. Most drugs will be available in maintenance quantities.
- Preventive drug coverage for select preventive drugs. The Preventive Drug List of drugs will be covered at a $0 copay. Prescriptions must be filled at a Marshfield Clinic Pharmacy to be eligible. The Preventive Drug List can be viewed on the website at: www.securityhealth.org/sas-prescriptiontools
- The Cancer Treatment Fairness Act limits copayments to no more than $100 for a one-month supply of oral chemotherapy drugs. An ancillary charge will be assessed above and beyond the $100 monthly maximum for brand name drugs where a generic is available. For high deductible health plans, the copayment limit applies only after the deductible has been satisfied for the year. The ancillary charge is the cost difference between the brand name drug and the generic drug. The ancillary charge will not count towards the prescription out-of-pocket limit.

Limitations

The benefits set forth in this section will be limited to:

- A Marshfield Clinic pharmacy must be used for maintenance, preventive, and specialty drugs. Antibiotics and certain Schedule II controlled substances, including some drugs for the treatment of pain or attention deficit do not apply to a Marshfield Clinic Pharmacy mandate. You may obtain these from any affiliated pharmacy.
- If you are prescribed a drug and must fill it at a non-Marshfield Clinic pharmacy the higher copay will apply. Only a 30-day supply of a maintenance drug will be allowed to be filled one time during the year. After that you will have no coverage unless you transfer to a Marshfield Clinic Pharmacy.
- Specialty prescription drugs are required to be obtained at a designated specialty pharmacy with which Security Health Plan has an arrangement to provide these prescriptions.
- Specialty prescription drugs are limited to a one month supply.
- Select specialty prescription drugs that are known to be poorly tolerated will be limited to a number of partial fills to assess Participant tolerability and drug reaction prior to obtaining a one month fill.

- Security Administrative Services reserves the right to limit coverage of daily dosing regimens to FDA-approved dosing as defined by the manufacturer and clinical best-practice guidelines
- The formulary is reviewed and updated every month. Most changes involve adding new drugs or drugs that are newly available in generic form. At times, drugs are removed from the formulary, change tier, or moved to restricted status. Members and providers are encouraged to review the Security Administrative Services website at www.sastpa.com/Pharmacy-Benefit on a regular basis for the most recent updates.
- Members who receive multiple opioid-based drugs from several different prescribers and several different pharmacies may be required to use only one pharmacy for future opioid-based drugs.
- Coverage of opioid drugs for acute pain may be limited to a 7-day supply.
- All prescriptions should be submitted electronically using your Security Administrative Services pharmacy card. For prescriptions not submitted electronically, any dollar amounts in excess of the electronic contracted charge for that drug will not be covered.
- All claims not submitted electronically should be sent to Security Administrative Services within 90 days of date of service.
- Non-formulary drugs may be covered when an exception is requested by the health care provider. The request should include the member name; health care provider's name, address and telephone number; drug strength, dosage form and directions; diagnosis; lab medical data; and the medical reason for the request. Written requests should be sent to:

  Security Administrative Services
  ATTN: Pharmacy Services PO Box 8000
  Marshfield, WI 54449-8000

  Or email us at: shprx@securityhealth.org

  Pharmacy Services can be reached at 1-877-873-5611

- Prescribed generic and brand-name drugs are subject to cost sharing. If either a covered brandname prescription drug, for which a generic equivalent is available, or a generic drug is prescribed, the prescription will be filled with the generic version. If you request the brand- name drug, you will be responsible for the cost-sharing that applies to the brand-name drug plus the cost difference between the brand name drug and the generic drug. The ancillary charge will not count towards the prescription out-of-pocket limit.
- Medical benefit drugs may require prior authorization, or preferred/alternative drugs to treat the same condition unless authorized by Security Administrative Services. Please refer to the Security Health Plan website at https://www.securityhealth.org/rxpa for the most up-to-date list of medical benefit drugs that require prior authorization.
- Prescription drug coupon amounts are not applied to the annual deductible and out-of-pocket limits.

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

Marshfield Clinic Health System, Inc.

By: Terri Newmier

Name: Terri Newmier

Date: April 24, 2020

Title: Interim Chief Human Resources Officer