

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
Hospital emergency room services <ul style="list-style-type: none"> Emergency room facility Balance of charge after copayment applies to annual deductible and coinsurance. Copayments continue after deductible and coinsurance have been satisfied. Other emergency room services 	<p>Subject \$200 copayment then deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p>	<p>Subject \$200 copayment then in-network deductible and coinsurance</p> <p>Subject to in-network deductible and coinsurance</p>
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 <ul style="list-style-type: none"> Hospital services Physician services Breast feeding support, supplies, counseling Breast Pump Gestational Diabetes treatment 	<p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Covered at 100%</p> <p>Covered at 100%</p> <p>Covered at 100%</p>	<p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p>
Mental health and substance abuse services <ul style="list-style-type: none"> Inpatient care Outpatient care Transitional care 	<p>Subject to deductible and coinsurance</p> <p>6 days covered at 100% per calendar year (when criteria is met) then subject to deductible and coinsurance</p> <p>6 days covered at 100% per calendar year (when criteria is met) then subject to deductible and coinsurance</p>	<p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p>
Nutritional Counseling Limited to 4 visits per calendar year	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Office visit	<p>Subject to deductible and coinsurance</p> <p>2 primary care physician office visits per individual per year covered at 100% before deductible and coinsurance are applied.</p>	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
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		
<ul style="list-style-type: none"> • Occupational therapy 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Physical therapy 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Speech therapy 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Physician services		
<ul style="list-style-type: none"> • Hospital services / surgery center 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Other services in an office 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Preventive benefit		
<p>Please refer to Security Administrative Services' Preventive Service Guidelines at www.securityhealth.org/preventive under Health Care Reform for service frequency recommendations.</p>		
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • Gynecological examination Breast exam and pelvic exam 	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Digital prostate examination 	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Preventive hearing test 	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Comprehensive preventive vision examination 	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Mammogram to screen for breast cancer 	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Pap smear to screen for cervical cancer 	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Colonoscopy screening for colorectal cancer 	1 every five years then subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Preventive Benefit Cont. <ul style="list-style-type: none"> • Sigmoidoscopy screening for colorectal cancer • Other screenings for colorectal cancer Fecal occult blood testing • 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. • Bone mineral density (dexa scan) to screen for osteoporosis • Chlamydia screening • HPV Screening / counseling • Ultrasound to screen for an abdominal aortic aneurysm • Immunizations and vaccinations Including those needed for travel 	<p>1 every five years then subject to deductible and coinsurance</p> <p>1 per calendar year then subject to deductible and coinsurance</p> <p>Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance</p> <p>1 per calendar year then subject to deductible and coinsurance</p> <p>1 per calendar year then subject to deductible and coinsurance</p> <p>1 per calendar year then subject to deductible and coinsurance</p> <p>1 per calendar year then subject to deductible and coinsurance</p> <p>Covered at 100%</p>	<p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p>
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 <ul style="list-style-type: none"> • Dialysis • Organ procurement and acquisition • Transplant procedure 	<p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p>	<p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p>
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	
<ul style="list-style-type: none"> • 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. 	<p>The following applies when filled at any MARSHFIELD CLINIC PHARMACY location:</p> <ul style="list-style-type: none"> • \$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). <p>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.</p> <p>The following benefit applies when filled at any NON-MARSHFIELD CLINIC PHARMACY location:</p> <ul style="list-style-type: none"> • \$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. <p>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.</p>

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).