Schedule of Benefits – Enrich Point of Service (POS)

Group - 670031- MARSHFIELD CLINIC HEALTH SYSTEM
Benefit Year: April 1st through March 31st
Effective Date: 04/01/2024

SecurityHealth Plan℠
Security Administrative Services

Security Administrative Services shows 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 Summary Plan Description.

This Schedule shows your specific cost-sharing, as well as any additional benefits, limitations or exclusions not shown in your Summary Plan Description. 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.

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

Your Responsibilities	In-network	Out-of-network
Deductible	$3,000 per individual $6,000 per family	$6,000 per individual $12,000 per family
Coinsurance	20%	40%
Office visit copayment	$30 copayment per office visit	Subject to deductible and coinsurance
Office visit specialist copayment	$60 copayment per office visit	Subject to deductible and coinsurance
Urgent care copayment	$30 copayment per office visit	$30 copayment per office visit
Emergency room copayment (Copayment waived if admitted to hospital as inpatient)	$250 copayment per visit Balance of charge after copayment applies to annual deductible and coinsurance. Copayments continue to apply until the annual out-of-pocket has been satisfied.	$250 copayment per visit Balance of charge after copayment applies to annual in-network deductible and coinsurance. Copayments continue to apply until the annual in-network out-of-pocket has been satisfied.

Your Responsibilities	In-network	Out-of-network
Annual out-of-pocket (Deductible, coinsurance & copayments) Out-of-network amounts accumulate to the in-and-out-of-network, out-of-pocket maximum.	$9,000 per individual $18,000 per family	$18,000 per individual $36,000 per family
Dependent wrap coverage In addition to the benefits described in the Follow-up Care section of the Summary Plan Description, dependents living outside of the service area are provided benefits for covered services from non-affiliated providers.	Such coverage shall be provided at the in-network level of benefits.	Such coverage shall be provided at the in-network level of benefits.

Your Benefits	In-network	Out-of-network
Ambulance services	Subject to deductible and coinsurance	Subject to in-network deductible and coinsurance
Anesthesia services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Breast cancer (BRCA 1 & 2) gene screening *~Requires prior authorization*	Covered at 100% (Limited to 1 visit per lifetime)	Subject to deductible and coinsurance (Limited to 1 visit per lifetime)
Care my way	Covered at 100%	Not applicable
Chiropractic services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Dry needling	Subject to deductible and coinsurance (Limited to 20 visits per individual per calendar year)	Subject to deductible and coinsurance (Limited to 20 visits per individual per calendar year)
Durable medical equipment and medical supplies *~Requires prior authorization*		
• **Approved to be dispensed from a supplier**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Approved to be dispensed from a network pharmacy**	Refer to pharmacy benefit for pharmacy cost-share	Refer to pharmacy benefit for pharmacy cost-share

Your Benefits	In-network	Out-of-network
Emergency services		
• **Emergency room facility** (Copayment waived if admitted to hospital as inpatient)	$250 copayment per visit Balance of charge after copayment applies to annual deductible and coinsurance. Copayments continue to apply until the annual out-of-pocket has been satisfied.	$250 copayment per visit Balance of charge after copayment applies to annual in-network deductible and coinsurance. Copayments continue to apply until the annual in-network out-of-pocket has been satisfied.
• **Other emergency services**	Subject to deductible and coinsurance	Subject to in-network deductible and coinsurance
Habilitative therapy		
• **Occupational therapy** *~Requires prior authorization*	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Physical therapy** *~Requires prior authorization*	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Speech therapy** *~Requires prior authorization*	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 *~Requires prior authorization*	Subject to deductible and coinsurance (Limited to 40 visits per individual per calendar year)	Subject to deductible and coinsurance (Limited to 40 visits per individual per calendar year)
Hospice care	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hospital services		
• **Inpatient hospital services** (Including semi-private or special care room, operating room, ancillary services and supplies) *~Requires prior authorization*	Subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	In-network	Out-of-network
• **Inpatient/residential mental health and substance use disorder services** *~Requires prior authorization*	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Outpatient hospital and surgical services** (not including emergency room)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Physician hospital services**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Other hospital services**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Infusion therapy		
• **Home infusion services** (when medically appropriate and provider available)	Covered at 100%	Subject to deductible and coinsurance
• **Outpatient services**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Maternity services		
• **Hospital services**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Physician services**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Mental health services		
• **Outpatient care**	6 days covered at 100% per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Transitional care**	6 days covered at 100% per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
Nutritional counseling	Subject to deductible and coinsurance	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

Your Benefits	In-network	Out-of-network
Physician services		
• **Office visits**	$30 copayment per office visit (Copayment does not apply to preventive exams)	Subject to deductible and coinsurance
• **Office visits with primary care physician (PCP)**	$30 copayment per office visit (Copayment does not apply to preventive exams)	Subject to deductible and coinsurance
• **Office visits with specialist**	$60 copayment per office visit	Subject to deductible and coinsurance
• **Other physician services in an office**	Subject to deductible and coinsurance (Preventive immunizations covered at 100%)	Subject to deductible and coinsurance
Preventive care services Please visit www.securityhealth.org/preventive or call 1-877-509-1952 for information on service frequency recommendations and a list of preventive screening services. Tests for an existing condition or illness are not preventive care and are subject to your plan's deductible, coinsurance and/or copays.	Scan this code with your smartphone	
• **Wellness visit** (comprehensive physical examination) ○ Well-baby care ○ Well-child care ○ Well-adolescent care ○ Well-adult care ○ Interpersonal and domestic violence screening ○ Nutritional screening ○ Screening and counseling for sexually transmitted infections	Covered at 100%	Subject to deductible and coinsurance

Your Benefits	In-network	Out-of-network
• **Abdominal aortic aneurysm (ultrasound) screening** (age 65 thru 75)	Covered at 100% (Limited to 1 visit per lifetime)	Subject to deductible and coinsurance (Limited to 1 visit per lifetime)
• **Breast feeding support and counseling**	Covered at 100%	Subject to deductible and coinsurance
• **Cervical cancer screenings** (age 21 thru 65)		
○ Human papillomavirus DNA screening (HPV)	1 every five years then subject to deductible and coinsurance	Subject to deductible and coinsurance
○ Pap smear screening	1 every three years 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
• **Colorectal cancer screenings**		
○ Colonoscopy screening (age 45 and older)	1 every five years then subject to deductible and coinsurance	Subject to deductible and coinsurance
○ Colonoscopy screening for personal or family history of polyps or colorectal cancer	1 every two years then subject to deductible and coinsurance	Subject to deductible and coinsurance
○ Sigmoidoscopy screening (age 45 and older)	1 every five years then subject to deductible and coinsurance	Subject to deductible and coinsurance
○ Sigmoidoscopy screening for personal or family history of polyps or colorectal cancer	1 every two years then subject to deductible and coinsurance	Subject to deductible and coinsurance
○ Other colorectal cancer screenings ~Fecal occult blood testing (age 45 and older)	1 per calendar year then subject to deductible and coinsurance	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

Your Benefits	In-network	Out-of-network
• **Hearing screening** (under age 22)	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
• **Laboratory screening services** Please visit www.securityhealth.org/preventive or call 1-877-509-1952 for information on service frequency recommendations and screening laboratory services.		
○ Cholesterol screening (age 40 thru 75)	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
○ Diabetes Type 2 screening (age 35 thru 70 with BMI 30+)	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
○ Hemoglobin (A1C) (diabetics)	2 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
○ Lead screening (age 1 thru 6)	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Mammogram to screen for breast cancer** (includes 2D and 3D imaging)	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Osteoporosis screening** Bone mineral density (dexa scan)	1 every two years then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Prostate cancer screenings**		
○ Digital examination	Subject to deductible and coinsurance	Subject to deductible and coinsurance
○ Prostate specific antigen test (PSA) (age 55 thru 69)	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Vision screenings**		
○ Pediatric/adolescent vision screening (under age 19)	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	In-network	Out-of-network
Rehabilitative therapy		
• **Occupational therapy** *~Requires prior authorization*	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Physical therapy** *~Requires prior authorization*	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Speech therapy** *~Requires prior authorization*	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Skilled nursing facility *~Requires prior authorization*	Subject to deductible and coinsurance (Limited to 30 days per individual per confinement)	Subject to deductible and coinsurance (Limited to 30 days per individual per confinement)
Substance use disorder services		
• **Outpatient care**	6 days covered at 100% per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Transitional care**	15 days covered at 100% per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
Surgical services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Temporomandibular joint disorders or TMJ non-surgical treatment *~Requires prior authorization*	Subject to deductible and coinsurance (Limited to 4 physical/occupational visits for diagnosis of TMJ per year)	Subject to deductible and coinsurance (Limited to 4 physical/occupational visits for diagnosis of TMJ per year)
Transplant services *~Requires prior authorization*	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Urgent care services		
• **Urgent care office visits**	$30 copayment per office visit	$30 copayment per office visit
• **Other urgent care services**	Subject to deductible and coinsurance	Subject to in-network deductible and coinsurance

Your Benefits	In-network	Out-of-network
Vision examinations	Subject to deductible and coinsurance	Subject to deductible and coinsurance

Pharmacy	
• 100% coverage for preventive prescription drugs (not subject to deductible, if applicable). 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 may supply maintenance prescription drugs in a 90-day supply and if applicable, 3 copayments and/or coinsurance will be assessed. • 100% coverage for oral anti-diabetic prescription drugs included on the Preventive Medication list (Not subject to deductible, if applicable.) • 100% coverage for insulin and diabetic testing supplies included on the Preventive Medication list (Not subject to deductible, if applicable.) • Diabetic prescription drugs, testing supplies and insulin not included on the Preventive Medication list will require medical exception review from the Security Health Plan Pharmacy Services Department. (This may not include all 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. • Specialty prescription drugs, as indicated in the formulary guide, must be filled at any Marshfield Clinic Pharmacy location.	The following benefit applies when filled at any MARSHFIELD CLINIC PHARMACY: $5 copayment per tier 1 prescription or refill. $40 copayment per tier 2 prescription or refill. $70 copayment per tier 3 prescription or refill. 30% coinsurance per tier 4 prescription or refill (specialty prescription drugs). The following benefit applies when filled at any NON MARSHFIELD CLINIC PHARMACY: $10 copayment per tier 1 prescription or refill. $80 copayment per tier 2 prescription or refill. $140 copayment per tier 3 prescription or refill. 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, 30% coinsurance will be assessed. Deductible, copayments and coinsurance may apply to the max out of pocket amounts. If the member receives the brand name prescription drug where a generic is available, the member 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.

Dependent Coverage
Dependent children are covered from birth through the end of the month they attain the age of 26. In addition, a child who meets the criteria above and is a full-time student as defined in this policy has an extension past age 26, if the child was called to federal active duty in the National Guard or in reserve component of the U.S. armed forces while the child was under age 27 and attending, on a full-time basis, an institution of higher learning. Such extension ends on the date described in the full-time student definition in the policy and any previous amendments.

Prior Authorization Note: It is your responsibility to ensure that the prior authorization is obtained and completed by your health care provider.
Your health care provider should start the prior authorization process by visiting www.securityhealth.org/providers or contact our Provider Assistance Line at 1-800-548-1224. You can also call our Customer Service Department at 1-877-509-1952 to find out what medical services require prior authorization. For a complete list of medical and pharmacy services requiring prior authorizations visit www.securityhealth.org/authorization or scan the QR code with your smartphone. Scan this code with your smartphone

Notice of Nondiscrimination
Security Health Plan of Wisconsin, Inc., complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, religion, disability, age, sex, gender identity, sexual orientation, health status, marital status, arrest or conviction record or military participation in the administration of the plan, including enrollment and benefit determinations.

Limited English Proficiency Language 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). If you require materials in large print, please call 1-877-509-1952 (TTY 711).