

**MARSHFIELD CLINIC HEALTH SYSTEM, INC
HEALTH PLAN**

**PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
AMENDMENT #1 TO MASTER PLAN DOCUMENT
EFFECTIVE: April 1, 2024**

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 CLAIM PROCEDURES; PAYMENT OF CLAIMS, Requirements for Second Level Appeal the following is removed:

To file for a review in writing, the Claimant’s request must be addressed as follows:

Marshfield Clinic Health System
Human Resources
1000 North Oak Ave
Marshfield, WI 54449

Phone: 1-800-472-2363
Fax: 1-715-221-9424
Email: shp.appeals.grievance@securityhealth.org

For urgent care pre-service review requests, please call 1-800-570-8760 or fax or email to the number and address listed above.

For Post-service Claims. To file for a review in writing, the Claimant’s review request must be addressed as follows:

Marshfield Clinic Health System
Human Resources
1000 North Oak Ave
Marshfield, WI 54449
Fax: 1-715-221-9424
Email: shp.appeals.grievance@securityhealth.org

And replaced with:

To file for a review in writing, the Claimant’s request must be addressed as follows:

Marshfield Clinic Health System, Inc
Terri Newmier, Chief Human Resources Officer
1000 North Oak Ave
Marshfield, WI 54449

Phone: 1-800-782-8581
Email: newmier.terri@marshfieldclinic.org

For urgent care pre-service review requests, please call 1-800-782-8581 or email to the address listed above.

For Post-service Claims. To file for a review in writing, the Claimant’s review request must be addressed as follows:

Marshfield Clinic Health System, Inc

Terri Newmier, Chief Human Resources Officer
1000 North Oak Ave
Marshfield, WI 54449

Phone: 1-800-782-8581

Email: newmier.terri@marshfieldclinic.org

The section entitled SUMMARY OF BENEFITS, the Summary of Benefits - Medical has been completely removed and replaced with:

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.

Schedule of Benefits – Enrich Point of Service (POS)

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.
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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		

<ul style="list-style-type: none"> • Inpatient hospital services (Including semi-private or special care room, operating room, ancillary services and supplies) <i>~Requires prior authorization</i> 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
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Your Benefits	In-network	Out-of-network
<ul style="list-style-type: none"> • Inpatient/residential mental health and substance use disorder services <i>~Requires prior authorization</i> 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Outpatient hospital and surgical services (not including emergency room) 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Physician hospital services 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Other hospital services 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Infusion therapy		
<ul style="list-style-type: none"> • Home infusion services (when medically appropriate and provider available) 	Covered at 100%	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Outpatient services 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Maternity services		
<ul style="list-style-type: none"> • Hospital services 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Physician services 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Mental health services		
<ul style="list-style-type: none"> • Outpatient care 	6 days covered at 100% per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • 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		
<ul style="list-style-type: none"> • Office visits 	\$30 copayment per office visit (Copayment does not apply to preventive exams)	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Office visits with primary care physician (PCP) 	\$30 copayment per office visit (Copayment does not apply to preventive exams)	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Office visits with specialist 	\$60 copayment per office visit	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Other physician services in an office 	Subject to deductible and coinsurance (Preventive immunizations covered at 100%)	Subject to deductible and coinsurance
Preventive care services		
<p>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.</p> <p>Tests for an existing condition or illness are not preventive care and are subject to your plan's deductible, coinsurance and/or copays.</p>	 Scan this code with your smartphone	
<ul style="list-style-type: none"> • Wellness visit (comprehensive physical examination) <ul style="list-style-type: none"> ○ 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
<ul style="list-style-type: none"> • 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)
<ul style="list-style-type: none"> • Breast feeding support and counseling 	Covered at 100%	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Cervical cancer screenings (age 21 thru 65) 		
<ul style="list-style-type: none"> ○ Human papillomavirus DNA screening (HPV) 	1 every five years then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> ○ Pap smear screening 	1 every three years then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Chlamydia screening 	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Colorectal cancer screenings 		
<ul style="list-style-type: none"> ○ Colonoscopy screening (age 45 and older) 	1 every five years then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> ○ 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
<ul style="list-style-type: none"> ○ Sigmoidoscopy screening (age 45 and older) 	1 every five years then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> ○ 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
<ul style="list-style-type: none"> ○ 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
<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

Your Benefits	In-network	Out-of-network
<ul style="list-style-type: none"> • Hearing screening (under age 22) 	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Immunizations and vaccinations (including those needed for travel) 	Covered at 100%	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • 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. 		
<ul style="list-style-type: none"> ○ Cholesterol screening (age 40 thru 75) 	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> ○ 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
<ul style="list-style-type: none"> ○ Hemoglobin (A1C) (diabetics) 	2 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> ○ Lead screening (age 1 thru 6) 	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 (includes 2D and 3D imaging) 	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Osteoporosis screening Bone mineral density (dexa scan) 	1 every two years then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Prostate cancer screenings 		
<ul style="list-style-type: none"> ○ Digital examination 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> ○ Prostate specific antigen test (PSA) (age 55 thru 69) 	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Vision screenings 		
<ul style="list-style-type: none"> ○ 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		

<ul style="list-style-type: none"> • Occupational therapy ~Requires prior authorization 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Physical therapy ~Requires prior authorization 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • 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		
<ul style="list-style-type: none"> • Outpatient care 	6 days covered at 100% per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • 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		
<ul style="list-style-type: none"> • Urgent care office visits 	\$30 copayment per office visit	\$30 copayment per office visit
<ul style="list-style-type: none"> • 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	
<ul style="list-style-type: none"> • 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. 	<p>The following benefit applies when filled at any MARSHFIELD CLINIC PHARMACY:</p> <p>\$5 copayment per tier 1 prescription or refill.</p> <p>\$40 copayment per tier 2 prescription or refill.</p> <p>\$70 copayment per tier 3 prescription or refill.</p> <p>30% coinsurance per tier 4 prescription or refill (specialty prescription drugs).</p> <p>The following benefit applies when filled at any NON MARSHFIELD CLINIC PHARMACY:</p> <p>\$10 copayment per tier 1 prescription or refill.</p> <p>\$80 copayment per tier 2 prescription or refill.</p> <p>\$140 copayment per tier 3 prescription or refill.</p> <p>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.</p> <p>Deductible, copayments and coinsurance may apply to the max out of pocket amounts.</p> <p>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.</p>

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 authorization visit www.securityhealth.org/authorization or scan the QR code with your smartphone.



Scan this code with your smartphone


Schedule of Benefits – Enrich HMO HDHP Elite

Your Responsibilities	
Deductible This plan is intended to qualify as a high deductible health plan that may be paired with a health savings account; however, you should check with your tax advisor for guidance on your particular situation.	\$5,000 per individual \$10,000 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.
Annual out-of-pocket (Deductible)	\$5,000 per individual \$10,000 per family The family annual out of pocket can be met by any combination of members within a family. If one family member meets the individual annual out of pocket, the annual out of pocket is satisfied for his or her claims. The maximum annual out of pocket is equal to the family annual out of pocket.

Your Responsibilities	
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.

Your Benefits	
Ambulance services	Subject to deductible
Anesthesia services	Subject to deductible
Breast cancer (BRCA 1 & 2) gene screening <i>~Requires prior authorization</i>	Covered at 100% (Limited to 1 visit per lifetime)
Care my way	Covered at 100%
Chiropractic services	Subject to deductible
Dry needling	Subject to deductible (Limited to 20 visits per individual per calendar year)
Durable medical equipment and medical supplies <i>~Requires prior authorization</i>	
<ul style="list-style-type: none"> • Approved to be dispensed from a supplier 	Subject to deductible
<ul style="list-style-type: none"> • Approved to be dispensed from a network pharmacy 	Refer to pharmacy benefit for pharmacy cost-share
Emergency services	
<ul style="list-style-type: none"> • Emergency room facility 	Subject to deductible
<ul style="list-style-type: none"> • Other emergency services 	Subject to deductible
Habilitative therapy	
<ul style="list-style-type: none"> • Occupational therapy <i>~Requires prior authorization</i> 	Subject to deductible
<ul style="list-style-type: none"> • Physical therapy <i>~Requires prior authorization</i> 	Subject to deductible
<ul style="list-style-type: none"> • Speech therapy <i>~Requires prior authorization</i> 	Subject to deductible
Hearing examinations (diagnostic)	Subject to deductible

Your Benefits	
Home health care <i>~Requires prior authorization</i>	Subject to deductible (Limited to 40 visits per individual per calendar year)
Hospice care	Subject to deductible
Hospital services	
<ul style="list-style-type: none"> • Inpatient hospital services (Including semi-private or special care room, operating room, ancillary services and supplies) <i>~Requires prior authorization</i> 	Subject to deductible
<ul style="list-style-type: none"> • Inpatient/residential mental health and substance use disorder services <i>~Requires prior authorization</i> 	Subject to deductible
<ul style="list-style-type: none"> • Outpatient hospital and surgical services (not including emergency room) 	Subject to deductible
<ul style="list-style-type: none"> • Physician hospital services 	Subject to deductible
<ul style="list-style-type: none"> • Other hospital services 	Subject to deductible
Infusion therapy	
<ul style="list-style-type: none"> • Home infusion services (when medically appropriate and provider available) 	Subject to deductible
<ul style="list-style-type: none"> • Outpatient services 	Subject to deductible
Maternity services	
<ul style="list-style-type: none"> • Hospital services 	Subject to deductible
<ul style="list-style-type: none"> • Physician services 	Subject to deductible
Mental health and substance use disorder services	
<ul style="list-style-type: none"> • Outpatient care 	Subject to deductible
<ul style="list-style-type: none"> • Transitional care 	Subject to deductible
Nutritional counseling	Subject to deductible
Outpatient laboratory services	Subject to deductible
Outpatient radiology services	Subject to deductible
Physician services	
<ul style="list-style-type: none"> • Office visits 	Subject to deductible (Preventive exams covered at 100%)

Your Benefits	
<ul style="list-style-type: none"> • Office visits with primary care physician (PCP) 	Subject to deductible (Preventive exams covered at 100%)
<ul style="list-style-type: none"> • Office visits with specialist 	Subject to deductible
<ul style="list-style-type: none"> • Other physician services in an office 	Subject to deductible (Preventive immunizations covered at 100%)
<p>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.</p> <p>Tests for an existing condition or illness are not preventive care and are subject to your plan's deductible, coinsurance and/or copays.</p>	 Scan this code with your smartphone
<ul style="list-style-type: none"> • Wellness visit (comprehensive physical examination) <ul style="list-style-type: none"> ○ 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%
<ul style="list-style-type: none"> • Abdominal aortic aneurysm (ultrasound) screening (age 65 thru 75) 	Covered at 100% (Limited to 1 visit per lifetime)
<ul style="list-style-type: none"> • Breast feeding support and counseling 	Covered at 100%
<ul style="list-style-type: none"> • Cervical cancer screenings (age 21 thru 65) <ul style="list-style-type: none"> ○ Human papillomavirus DNA screening (HPV) ○ Pap smear screening 	1 every five years then subject to deductible 1 every three years then subject to deductible
<ul style="list-style-type: none"> • Chlamydia screening 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> • Colorectal cancer screenings <ul style="list-style-type: none"> ○ Colonoscopy screening (age 45 and older) 	1 every five years then subject to deductible

Your Benefits	
<ul style="list-style-type: none"> ○ Colonoscopy screening for personal or family history of polyps or colorectal cancer 	1 every two years then subject to deductible
<ul style="list-style-type: none"> ○ Sigmoidoscopy screening (age 45 and older) 	1 every five years then subject to deductible
<ul style="list-style-type: none"> ○ Sigmoidoscopy screening for personal or family history of polyps or colorectal cancer 	1 every two years then subject to deductible
<ul style="list-style-type: none"> ○ Other colorectal cancer screenings ~Fecal occult blood testing (age 45 and older) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> ● Gynecological examination (breast exam and pelvic exam) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> ● Hearing screening (under age 22) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> ● Immunizations and vaccinations (including those needed for travel) 	Covered at 100%
<ul style="list-style-type: none"> ● Laboratory screening services For a complete list of screening laboratory services and frequency recommendations please refer to Security Health Plan's Preventive Service Guidelines at www.securityhealth.org/preventive or contact us at 1-877-509-1952. 	
<ul style="list-style-type: none"> ○ Cholesterol screening (age 40 thru 75) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> ○ Diabetes Type 2 screening (age 35 thru 70 with BMI 30+) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> ○ Hemoglobin (A1C) (diabetics) 	2 per calendar year then subject to deductible
<ul style="list-style-type: none"> ○ Lead screening (age 1 thru 6) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> ● Mammogram to screen for breast cancer (includes 2D and 3D imaging) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> ● Osteoporosis screening Bone mineral density (dexa scan) 	1 every two years then subject to deductible
<ul style="list-style-type: none"> ● Prostate cancer screenings <ul style="list-style-type: none"> ○ Digital examination 	Subject to deductible

Your Benefits	
<ul style="list-style-type: none"> ○ Prostate specific antigen test (PSA) (age 55 thru 69) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> ● Vision screenings 	
<ul style="list-style-type: none"> ○ Pediatric/adolescent vision screening (under age 19) 	1 per calendar year then subject to deductible
Rehabilitative therapy	
<ul style="list-style-type: none"> ● Occupational therapy ~Requires prior authorization 	Subject to deductible
<ul style="list-style-type: none"> ● Physical therapy ~Requires prior authorization 	Subject to deductible
<ul style="list-style-type: none"> ● Speech therapy ~Requires prior authorization 	Subject to deductible
Skilled nursing facility ~Requires prior authorization	Subject to deductible (Limited to 30 days per individual per confinement)
Surgical services	Subject to deductible
Temporomandibular joint disorders or TMJ non-surgical treatment ~Requires prior authorization	Subject to deductible (Limited to 4 physical/occupational visits for diagnosis of TMJ per year)
Transplant services ~Requires prior authorization	Subject to deductible
Urgent care services	
<ul style="list-style-type: none"> ● Urgent care office visits 	Subject to deductible
<ul style="list-style-type: none"> ● Other urgent care services 	Subject to deductible
Vision examinations	Subject to deductible

Pharmacy	
<ul style="list-style-type: none"> • 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. • 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. 	<p>Subject to deductible.</p> <p>Deductible, copayments and coinsurance may apply to the max out of pocket amounts.</p> <p>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.</p>

Dependent Coverage
<p>Dependent children are covered from birth through the end of the month they attain the age of 26.</p> <p>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.</p>

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 authorization visit www.securityhealth.org/authorization or scan the QR code with your smartphone.



Scan this code with your smartphone

Schedule of Benefits – Enrich HMO HDHP Plus

Your Responsibilities	
Deductible This plan is intended to qualify as a high deductible health plan that may be paired with a health savings account; however, you should check with your tax advisor for guidance on your particular situation.	\$3,500 per individual \$7,000 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.
Annual out-of-pocket (Deductible)	\$3,500 per individual \$7,000 per family The family annual out of pocket can be met by any combination of members within a family. If one family member meets the individual annual out of pocket, the annual out of pocket is satisfied for his or her claims. The maximum annual out of pocket is equal to the family annual out of pocket.

Your Responsibilities	
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.


Your Benefits	
Ambulance services	Subject to deductible
Anesthesia services	Subject to deductible

Breast cancer (BRCA 1 & 2) gene screening <i>~Requires prior authorization</i>	Covered at 100% (Limited to 1 visit per lifetime)
Care my way	Covered at 100%
Chiropractic services	Subject to deductible
Dry needling	Subject to deductible (Limited to 20 visits per individual per calendar year)
Durable medical equipment and medical supplies <i>~Requires prior authorization</i>	
• Approved to be dispensed from a supplier	Subject to deductible
• Approved to be dispensed from a network pharmacy	Refer to pharmacy benefit for pharmacy cost-share
Emergency services	
• Emergency room facility	Subject to deductible
• Other emergency services	Subject to deductible
Habilitative therapy	
• Occupational therapy <i>~Requires prior authorization</i>	Subject to deductible
• Physical therapy <i>~Requires prior authorization</i>	Subject to deductible
• Speech therapy <i>~Requires prior authorization</i>	Subject to deductible
Hearing examinations (diagnostic)	Subject to deductible

Your Benefits	
Home health care <i>~Requires prior authorization</i>	Subject to deductible (Limited to 40 visits per individual per calendar year)
Hospice care	Subject to deductible
Hospital services	
• Inpatient hospital services (Including semi-private or special care room, operating room, ancillary services and supplies) <i>~Requires prior authorization</i>	Subject to deductible
• Inpatient/residential mental health and substance use disorder services <i>~Requires prior authorization</i>	Subject to deductible

<ul style="list-style-type: none"> • Outpatient hospital and surgical services (not including emergency room) 	Subject to deductible
<ul style="list-style-type: none"> • Physician hospital services 	Subject to deductible
<ul style="list-style-type: none"> • Other hospital services 	Subject to deductible
Infusion therapy	
<ul style="list-style-type: none"> • Home infusion services (when medically appropriate and provider available) 	Subject to deductible
<ul style="list-style-type: none"> • Outpatient services 	Subject to deductible
Maternity services	
<ul style="list-style-type: none"> • Hospital services 	Subject to deductible
<ul style="list-style-type: none"> • Physician services 	Subject to deductible
Mental health and substance use disorder services	
<ul style="list-style-type: none"> • Outpatient care 	Subject to deductible
<ul style="list-style-type: none"> • Transitional care 	Subject to deductible
Nutritional counseling	Subject to deductible
Outpatient laboratory services	Subject to deductible
Outpatient radiology services	Subject to deductible
Physician services	
<ul style="list-style-type: none"> • Office visits 	Subject to deductible (Preventive exams covered at 100%)

Your Benefits	
<ul style="list-style-type: none"> • Office visits with primary care physician (PCP) 	Subject to deductible (Preventive exams covered at 100%)
<ul style="list-style-type: none"> • Office visits with specialist 	Subject to deductible
<ul style="list-style-type: none"> • Other physician services in an office 	Subject to deductible (Preventive immunizations covered at 100%)

<p>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.</p> <p>Tests for an existing condition or illness are not preventive care and are subject to your plan's deductible, coinsurance and/or copays.</p>	 <p>Scan this code with your smartphone</p>
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<ul style="list-style-type: none"> ● Wellness visit (comprehensive physical examination) <ul style="list-style-type: none"> ○ 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%
<ul style="list-style-type: none"> ● Abdominal aortic aneurysm (ultrasound) screening (age 65 thru 75) 	Covered at 100% (Limited to 1 visit per lifetime)
<ul style="list-style-type: none"> ● Breast feeding support and counseling 	Covered at 100%
<ul style="list-style-type: none"> ● Cervical cancer screenings (age 21 thru 65) 	
<ul style="list-style-type: none"> ○ Human papillomavirus DNA screening (HPV) 	1 every five years then subject to deductible
<ul style="list-style-type: none"> ○ Pap smear screening 	1 every three years then subject to deductible
<ul style="list-style-type: none"> ● Chlamydia screening 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> ● Colorectal cancer screenings 	
<ul style="list-style-type: none"> ○ Colonoscopy screening (age 45 and older) 	1 every five years then subject to deductible

Your Benefits	
<ul style="list-style-type: none"> ○ Colonoscopy screening for personal or family history of polyps or colorectal cancer 	1 every two years then subject to deductible
<ul style="list-style-type: none"> ○ Sigmoidoscopy screening (age 45 and older) 	1 every five years then subject to deductible
<ul style="list-style-type: none"> ○ Sigmoidoscopy screening for personal or family history of polyps or colorectal cancer 	1 every two years then subject to deductible
<ul style="list-style-type: none"> ○ Other colorectal cancer screenings ~Fecal occult blood testing (age 45 and older) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> ● Gynecological examination (breast exam and pelvic exam) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> ● Hearing screening (under age 22) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> ● Immunizations and vaccinations (including those needed for travel) 	Covered at 100%

<ul style="list-style-type: none"> • Laboratory screening services For a complete list of screening laboratory services and frequency recommendations please refer to Security Health Plan's Preventive Service Guidelines at www.securityhealth.org/preventive or contact us at 1-877-509-1952. 	
<ul style="list-style-type: none"> ○ Cholesterol screening (age 40 thru 75) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> ○ Diabetes Type 2 screening (age 35 thru 70 with BMI 30+) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> ○ Hemoglobin (A1C) (diabetics) 	2 per calendar year then subject to deductible
<ul style="list-style-type: none"> ○ Lead screening (age 1 thru 6) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> • Mammogram to screen for breast cancer (includes 2D and 3D imaging) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> • Osteoporosis screening Bone mineral density (dexa scan) 	1 every two years then subject to deductible
<ul style="list-style-type: none"> • Prostate cancer screenings 	
<ul style="list-style-type: none"> ○ Digital examination 	Subject to deductible

Your Benefits	
<ul style="list-style-type: none"> ○ Prostate specific antigen test (PSA) (age 55 thru 69) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> • Vision screenings 	
<ul style="list-style-type: none"> ○ Pediatric/adolescent vision screening (under age 19) 	1 per calendar year then subject to deductible
Rehabilitative therapy	
<ul style="list-style-type: none"> • Occupational therapy <i>~Requires prior authorization</i> 	Subject to deductible
<ul style="list-style-type: none"> • Physical therapy <i>~Requires prior authorization</i> 	Subject to deductible
<ul style="list-style-type: none"> • Speech therapy <i>~Requires prior authorization</i> 	Subject to deductible
Skilled nursing facility <i>~Requires prior authorization</i>	Subject to deductible (Limited to 30 days per individual per confinement)
Surgical services	Subject to deductible

Temporomandibular joint disorders or TMJ non-surgical treatment <i>~Requires prior authorization</i>	Subject to deductible (Limited to 4 physical/occupational visits for diagnosis of TMJ per year)
Transplant services <i>~Requires prior authorization</i>	Subject to deductible
Urgent care services	
• Urgent care office visits	Subject to deductible
• Other urgent care services	Subject to deductible
Vision examinations	Subject to deductible

Pharmacy	
<ul style="list-style-type: none"> • 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. • 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. 	<p>Subject to deductible.</p> <p>Deductible, copayments and coinsurance may apply to the max out of pocket amounts.</p> <p>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.</p>

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

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Schedule of Benefits – Explore HMO HDHP

Your Responsibilities	
Deductible This plan is intended to qualify as a high deductible health plan that may be paired with a health savings account; however, you should check with your tax advisor for guidance on your particular situation.	\$3,500 per individual \$7,000 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.
Annual out-of-pocket (Deductible)	\$3,500 per individual \$7,000 per family The family annual out of pocket can be met by any combination of members within a family. If one family member meets the individual annual out of pocket, the annual out of pocket is satisfied for his or her claims. The maximum annual out of pocket is equal to the family annual out of pocket.
Your Benefits	
Ambulance services	Subject to deductible

Anesthesia services	Subject to deductible
Breast cancer (BRCA 1 & 2) gene screening ~Requires prior authorization	Covered at 100% (Limited to 1 visit per lifetime)
Care my way	Covered at 100%
Chiropractic services	Subject to deductible
Your Benefits	
Dry needling	Subject to deductible (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
• Approved to be dispensed from a network pharmacy	Refer to pharmacy benefit for pharmacy cost-share
Emergency services	
• Emergency room facility	Subject to deductible
• Other emergency services	Subject to deductible
Habilitative therapy	
• Occupational therapy ~Requires prior authorization	Subject to deductible
• Physical therapy ~Requires prior authorization	Subject to deductible
• Speech therapy ~Requires prior authorization	Subject to deductible
Hearing examinations (diagnostic)	Subject to deductible
Home health care ~Requires prior authorization	Subject to deductible (Limited to 40 visits per individual per calendar year)
Hospice care	Subject to deductible
Hospital services	
• Inpatient hospital services (Including semi-private or special care room, operating room, ancillary services and supplies) ~Requires prior authorization	Subject to deductible
• Inpatient/residential mental health and substance use disorder services ~Requires prior authorization	Subject to deductible

<ul style="list-style-type: none"> • Outpatient hospital and surgical services (not including emergency room) 	Subject to deductible
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Your Benefits	
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<ul style="list-style-type: none"> • Physician hospital services 	Subject to deductible
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<ul style="list-style-type: none"> • Other hospital services 	Subject to deductible
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Infusion therapy	
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<ul style="list-style-type: none"> • Home infusion services (when medically appropriate and provider available) 	Subject to deductible
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<ul style="list-style-type: none"> • Outpatient services 	Subject to deductible
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Maternity services	
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<ul style="list-style-type: none"> • Hospital services 	Subject to deductible
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<ul style="list-style-type: none"> • Physician services 	Subject to deductible
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Mental health and substance use disorder services	
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<ul style="list-style-type: none"> • Outpatient care 	Subject to deductible
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<ul style="list-style-type: none"> • Transitional care 	Subject to deductible
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Nutritional counseling	Subject to deductible
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Outpatient laboratory services	Subject to deductible
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Outpatient radiology services	Subject to deductible
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Physician services	
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<ul style="list-style-type: none"> • Office visits 	Subject to deductible (Preventive exams covered at 100%)
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<ul style="list-style-type: none"> • Office visits with primary care physician (PCP) 	Subject to deductible (Preventive exams covered at 100%)
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<ul style="list-style-type: none"> • Office visits with specialist 	Subject to deductible
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<ul style="list-style-type: none"> • Other physician services in an office 	Subject to deductible (Preventive immunizations covered at 100%)
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Your Benefits	
<p>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.</p> <p>Tests for an existing condition or illness are not preventive care and are subject to your plan's deductible, coinsurance and/or copays.</p>	 Scan this code with your smartphone
<ul style="list-style-type: none"> • Wellness visit (comprehensive physical examination) <ul style="list-style-type: none"> ○ 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%
<ul style="list-style-type: none"> • Abdominal aortic aneurysm (ultrasound) screening (age 65 thru 75) 	Covered at 100% (Limited to 1 visit per lifetime)
<ul style="list-style-type: none"> • Breast feeding support and counseling 	Covered at 100%
<ul style="list-style-type: none"> • Cervical cancer screenings (age 21 thru 65) <ul style="list-style-type: none"> ○ Human papillomavirus DNA screening (HPV) ○ Pap smear screening 	1 every five years then subject to deductible 1 every three years then subject to deductible
<ul style="list-style-type: none"> • Chlamydia screening 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> • Colorectal cancer screenings <ul style="list-style-type: none"> ○ Colonoscopy screening (age 45 and older) ○ Colonoscopy screening for personal or family history of polyps or colorectal cancer ○ Sigmoidoscopy screening (age 45 and older) ○ Sigmoidoscopy screening for personal or family history of polyps or colorectal cancer 	1 every five years then subject to deductible 1 every two years then subject to deductible 1 every five years then subject to deductible 1 every two years then subject to deductible
Your Benefits	
<ul style="list-style-type: none"> ○ Other colorectal cancer screenings ~Fecal occult blood testing (age 45 and older) 	1 per calendar year then subject to deductible

<ul style="list-style-type: none"> • Gynecological examination (breast exam and pelvic exam) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> • Hearing screening (under age 22) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> • Immunizations and vaccinations (including those needed for travel) 	Covered at 100%
<ul style="list-style-type: none"> • Laboratory screening services For a complete list of screening laboratory services and frequency recommendations please refer to Security Health Plan's Preventive Service Guidelines at www.securityhealth.org/preventive or contact us at 1-877-509-1952. 	
<ul style="list-style-type: none"> ○ Cholesterol screening (age 40 thru 75) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> ○ Diabetes Type 2 screening (age 35 thru 70 with BMI 30+) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> ○ Hemoglobin (A1C) (diabetics) 	2 per calendar year then subject to deductible
<ul style="list-style-type: none"> ○ Lead screening (age 1 thru 6) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> • Mammogram to screen for breast cancer (includes 2D and 3D imaging) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> • Osteoporosis screening Bone mineral density (dexa scan) 	1 every two years then subject to deductible
<ul style="list-style-type: none"> • Prostate cancer screenings 	
<ul style="list-style-type: none"> ○ Digital examination 	Subject to deductible
<ul style="list-style-type: none"> ○ Prostate specific antigen test (PSA) (age 55 thru 69) 	1 per calendar year then subject to deductible
<ul style="list-style-type: none"> • Vision screenings 	
<ul style="list-style-type: none"> ○ Pediatric/adolescent vision screening (under age 19) 	1 per calendar year then subject to deductible

Your Benefits	
Rehabilitative therapy	
<ul style="list-style-type: none"> • Occupational therapy <i>~Requires prior authorization</i> 	Subject to deductible
<ul style="list-style-type: none"> • Physical therapy <i>~Requires prior authorization</i> 	Subject to deductible
<ul style="list-style-type: none"> • Speech therapy <i>~Requires prior authorization</i> 	Subject to deductible

Skilled nursing facility <i>~Requires prior authorization</i>	Subject to deductible (Limited to 30 days per individual per confinement)
Surgical services	Subject to deductible
Temporomandibular joint disorders or TMJ non-surgical treatment <i>~Requires prior authorization</i>	Subject to deductible (Limited to 4 physical/occupational visits for diagnosis of TMJ per year)
Transplant services <i>~Requires prior authorization</i>	Subject to deductible
Urgent care services	
• Urgent care office visits	Subject to deductible
• Other urgent care services	Subject to deductible
Vision examinations	Subject to deductible

Pharmacy	
<ul style="list-style-type: none"> • 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. • 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. 	<p>Subject to deductible.</p> <p>Deductible, copayments and coinsurance may apply to the max out of pocket amounts.</p> <p>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.</p>

Dependent Coverage
<p>Dependent children are covered from birth through the end of the month they attain the age of 26.</p> <p>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.</p>

Prior Authorization

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Schedule of Benefits – Active Advantage J1 Visa

Your Responsibilities	In-network	Out-of-network
Deductible	\$500 per individual \$1,000 per family	\$1,000 per individual \$2,000 per family
Coinsurance	20%	40%
Emergency room facility copayment (Copayment waived if admitted to hospital as inpatient)	\$200 copayment per visit Balance of charge after copayment applies to annual deductible and coinsurance. Copayments continue to apply until the annual out-of-pocket has been satisfied.	\$200 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.
Annual out-of-pocket (Deductible, coinsurance & copayments) Out-of-network amounts accumulate to the in-and-out-of-network, out-of-pocket maximum.	\$6,550 per individual \$13,100 per family	\$13,100 per individual \$26,200 per family

Your Benefits	In-network	Out-of-network
Ambulance services	Subject to deductible and coinsurance	Subject to in-network deductible and coinsurance

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

	(Limited to 1 visit per lifetime)	(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
Chronic care management		
<ul style="list-style-type: none"> Asthma care management 	<p>Office visits with your asthma care provider are limited to 4 visits per individual per benefit year then subject to deductible and coinsurance</p> <p>Unlimited spirometry services</p> <p>Unlimited asthma care kits</p> <p>Unlimited peak flow meters</p> <p>Unlimited spacers</p> <p>Asthma medications identified on the asthma medications list for members in the asthma disease management program are covered at 100%</p>	Subject to deductible and coinsurance

Your Benefits	In-network	Out-of-network
<ul style="list-style-type: none"> • Diabetes care management 	<p>Office visits with your diabetes care provider are limited to 4 visits per individual per benefit year then subject to deductible and coinsurance</p> <p>Unlimited services for diabetes outpatient self-management education</p> <p>Medical nutrition therapy services are limited to 4 visits with a registered dietician per individual per benefit year (refer to Summary Plan Description)</p> <p>Vision examinations are limited to 1 examination per individual per benefit year</p> <p>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</p>	<p>Subject to deductible and coinsurance</p>
<ul style="list-style-type: none"> • High cholesterol care management 	<p>The following lab services are covered at 100%: lipid panel, lipoprotein or triglycerides</p>	<p>Subject to deductible and coinsurance</p>
<p>Dry needling</p>	<p>Subject to deductible and coinsurance</p> <p>(Limited to 20 visits per individual per calendar year)</p>	<p>Subject to deductible and coinsurance</p> <p>(Limited to 20 visits per individual per calendar year)</p>


Your Benefits	In-network	Out-of-network
Durable medical equipment and medical supplies ~Requires prior authorization		
<ul style="list-style-type: none"> • Approved to be dispensed from a supplier 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Approved to be dispensed from a network pharmacy 	Refer to pharmacy benefit for pharmacy cost-share	Refer to pharmacy benefit for pharmacy cost-share
Emergency services		
<ul style="list-style-type: none"> • Emergency room facility (Copayment waived if admitted to hospital as inpatient) 	\$200 copayment per visit Balance of charge after copayment applies to annual deductible and coinsurance. Copayments continue to apply until the annual out-of-pocket has been satisfied.	\$200 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.
<ul style="list-style-type: none"> • Other emergency services 	Subject to deductible and coinsurance	Subject to in-network deductible and coinsurance
Habilitative therapy		
<ul style="list-style-type: none"> • Occupational therapy ~Requires prior authorization 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Physical therapy ~Requires prior authorization 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • 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

Your Benefits	In-network	Out-of-network
Hospital services		

<ul style="list-style-type: none"> • Inpatient hospital services (Including semi-private or special care room, operating room, ancillary services and supplies) <i>~Requires prior authorization</i> 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Inpatient/residential mental health and substance use disorder services <i>~Requires prior authorization</i> 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Outpatient hospital and surgical services (not including emergency room) 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Physician hospital services 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Other hospital services 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Infusion therapy		
<ul style="list-style-type: none"> • Home infusion services (when medically appropriate and provider available) 	Covered at 100%	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Outpatient services 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Maternity services		
<ul style="list-style-type: none"> • Hospital services 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Physician services 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Mental health services		
<ul style="list-style-type: none"> • Outpatient care 	6 days covered at 100% per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Transitional care 	6 days covered at 100% per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	In-network	Out-of-network
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

Physician services		
<ul style="list-style-type: none"> • Office visits 	Subject to deductible and coinsurance (Preventive exams covered at 100%)	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Office visits with primary care physician (PCP) 	Subject to deductible and coinsurance 2 primary care physician office visits per individual per year covered at 100% before deductible and coinsurance are applied. (Preventive exams covered at 100%)	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Office visits with specialist 	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> • Other physician services in an office 	Subject to deductible and coinsurance (Preventive immunizations covered at 100%)	Subject to deductible and coinsurance

Your Benefits	In-network	Out-of-network
<p>Preventive care services</p> <p>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.</p> <p>Tests for an existing condition or illness are not preventive care and are subject to your plan's deductible, coinsurance and/or copays.</p>	 <p>Scan this code with your smartphone</p>	

<ul style="list-style-type: none"> ● Wellness visit (comprehensive physical examination) <ul style="list-style-type: none"> ○ 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
<ul style="list-style-type: none"> ● 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)
<ul style="list-style-type: none"> ● Breast feeding support and counseling 	Covered at 100%	Subject to deductible and coinsurance
<ul style="list-style-type: none"> ● Cervical cancer screenings (age 21 thru 65) 		
<ul style="list-style-type: none"> ○ Human papillomavirus DNA screening (HPV) 	1 every five years then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> ○ Pap smear screening 	1 every three years then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> ● Chlamydia screening 	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	In-network	Out-of-network
<ul style="list-style-type: none"> ● Colorectal cancer screenings 		
<ul style="list-style-type: none"> ○ Colonoscopy screening (age 45 and older) 	1 every five years then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> ○ 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
<ul style="list-style-type: none"> ○ 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
● 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

Your Benefits	In-network	Out-of-network
○ 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
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

Your Benefits	In-network	Out-of-network
● 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	Subject to deductible and coinsurance	Subject to in-network deductible and coinsurance
• Other urgent care services	Subject to deductible and coinsurance	Subject to in-network deductible and coinsurance
Vision examinations	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). 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. 	<p>The following benefit applies when filled at any MARSHFIELD CLINIC PHARMACY:</p> <p>\$5 copayment per tier 1 prescription or refill.</p> <p>\$30 copayment per tier 2 prescription or refill.</p> <p>\$60 copayment per tier 3 prescription or refill.</p> <p>25% coinsurance per tier 4 prescription or refill (specialty prescription drugs).</p> <p>The following benefit applies when filled at any NON MARSHFIELD CLINIC PHARMACY:</p> <p>\$10 copayment per tier 1 prescription or refill.</p> <p>\$50 copayment per tier 2 prescription or refill.</p> <p>Tier 3 drugs-member pays the greater of \$100 or 50% of the cost of prescriptions.</p> <p>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> <p>Deductible, copayments and coinsurance may apply to the max out of pocket amounts.</p> <p>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.</p>

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 authorization visit www.securityhealth.org/authorization or scan the QR code with your smartphone.



Scan this code with your smartphone

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

Marshfield Clinic Health System, Inc.

By: Terri Newmier

Name: Terri Newmier

Date: May 23, 2024

Title: Chief Human Resources Officer