MARSHFIELD CLINIC HEALTH SYSTEM, INC
HEALTH PLAN

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
AMENDMENT #2 TO MASTER PLAN DOCUMENT
EFFECTIVE: April 1, 2025

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

The section entitled DEFINITIONS, the term "Substance Abuse Treatment Center" is removed and replaced with the following:

"Substance Use Disorder Treatment Center"
"Substance Use Disorder Treatment Center" shall mean an Institution whose facility is licensed, certified or approved as a Substance Use Disorder Treatment Center by a Federal, State, or other agency having legal authority to so license. Where applicable, the "Substance Use Disorder Treatment Center" must also be appropriately accredited by the Joint Commission on Accreditation of Hospitals.

The section entitled CONTINUATION OF COVERATE, the following is added:

Continuation During Family and Medical Leave Act (FMLA) Leave

The Plan shall at all times comply with FMLA. It is the intention of the Plan Administrator to provide these benefits only to the extent required by applicable law and not to grant greater rights than those so required. During a FMLA Leave, coverage will be maintained in accordance with the same Plan conditions as coverage would otherwise be provided if the covered Employee had been a continuously active employee during the entire leave period. If Plan coverage lapses during the FMLA Leave, coverage will be reinstated for the person(s) who had coverage under the Plan when the FMLA Leave began, upon the Employee's return to work at the conclusion of the FMLA Leave.

To the extent this Plan is required to comply with a State family and medical leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such State family and medical leave law, as well as under FMLA.

The section entitled MEDICARE has been completely removed and replaced with:

Applicable to Active Employees and Their Spouses Ages 65 and Over

An Active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the section entitled "Coordination of Benefits"). If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Participants Who Are Covered Under This Plan

If any Participant is enrolled in Medicare coverage because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of the Participant's Medicare entitlement, regardless of the date of enrollment, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

The section entitled THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT has been completely removed and replaced with:

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to crime victim restitution funds, civil restitution funds, no-fault restitution funds (including vaccine injury compensation funds), uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party, any medical, applicable disability, or other benefit payments, and school insurance coverage (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

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

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

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

If the Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other guarantor on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a responsible third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any of the following:
    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - Excluding school type insurance, vision only and dental only

the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan. Additionally, the Participant shall indemnify the Plan against any of the Participant's attorney's fees, costs, or other expenses related to the Participant's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury or disability.

Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other

means arising from any Injury or Accident. By virtue of this status, the Participant understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) ("Incurred") prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

Excess Insurance

Except as outlined in the "Effect on Benefits" provision in regard to any Other Plan, if at the time of Injury, Illness or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other guarantor on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a responsible third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any of the following:
    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical or other benefit payments
    - Excluding school-type insurance coverage, vision only and dental only

Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Illness, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
9. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
10. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, or to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's

subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

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

Schedule of Benefits – Enrich Point of Service (POS) Group #670031

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 of Benefits 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
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.

Annual out-of-pocket (Deductible, coinsurance and 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

Your responsibilities	**In-network**	**Out-of-network**
Dependent wrap coverage In addition to the benefits described in the Certificate, dependents living outside of the service area are provided benefits for covered services from out-of-network providers.	Such coverage shall be provided at the in-network level of benefits. Usual, Customary and Reasonable (UCR) fees may apply.	Such coverage shall be provided at the in-network level of benefits. Usual, Customary and Reasonable (UCR) fees may apply.

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 and 2) gene screening ~*Requires prior authorization*	Covered at 100% (Limited to 1 test per lifetime, or, if appropriate as determined by attending provider and meets medically necessity criteria)	Subject to deductible and coinsurance (Limited to 1 test per lifetime, or, if appropriate as determined by attending provider and meets medically necessity criteria)
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 (Preventive exams covered at 100%)	Subject to deductible and coinsurance

• **Office visits with primary care physician (PCP)**	$30 copayment per office visit (Preventive exams covered at 100%)	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.		
• **Preventive exams** (comprehensive physical examination) o Well-baby care o Well-child care o Well-adolescent care o Well-adult care o Interpersonal and domestic violence screening o Nutritional screening o 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 through 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 through 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 through 75)	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance

○ Diabetes Type 2 screening (age 35 through 70 with BMI 25+)	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 through 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 density)** ○ Routine osteoporosis screening (age 65 and older) ○ Osteoporosis screening for personal or family history or at increased risk (under age 65)	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 through 69)	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance

Your benefits	**In-network**	**Out-of-network**
• **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
• **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

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

Pharmacy	
• 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 Diabetic list (Not subject to deductible, if applicable.) • 100% coverage for insulin and diabetic testing supplies included on the Diabetic list (Not subject to deductible, if applicable.) • Diabetic prescription drugs, testing supplies and insulin not included on the Diabetic 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.

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 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 Group #100214

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 of Benefits 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	
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.
Coinsurance	20%
Annual out-of-pocket (Deductible and coinsurance)	$6,000 per individual $12,000 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.

Dependent wrap coverage In addition to the benefits described in the Summary Plan Description, dependents living outside of the service area are provided benefits for covered services from out-of-network providers.	Such coverage shall be provided at the in-network level of benefits. Usual, Customary and Reasonable (UCR) fees may apply.

Your benefits	
Ambulance services	Subject to deductible and coinsurance
Anesthesia services	Subject to deductible and coinsurance
Breast cancer (BRCA 1 and 2) gene screening *~Requires prior authorization*	Covered at 100% (Limited to 1 test per lifetime, or, if appropriate as determined by attending provider and meets medically necessity criteria)
Care My Way ®	Subject to deductible
Chiropractic services	Subject to deductible and coinsurance
Dry needling	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
• **Approved to be dispensed from a network pharmacy**	Refer to pharmacy benefit for pharmacy cost-share
Emergency services	
• **Emergency room facility**	Subject to deductible and coinsurance
• **Other emergency services**	Subject to deductible and coinsurance
Habilitative therapy	
• **Occupational therapy** *~Requires prior authorization*	Subject to deductible and coinsurance
• **Physical therapy** *~Requires prior authorization*	Subject to deductible and coinsurance
• **Speech therapy** *~Requires prior authorization*	Subject to deductible and coinsurance
Hearing examinations (diagnostic)	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)
Hospice care	Subject to deductible and coinsurance

Your benefits	
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
• **Inpatient/residential mental health and substance use disorder services** *~Requires prior authorization*	Subject to deductible and coinsurance
• **Outpatient hospital and surgical services** (not including emergency room)	Subject to deductible and coinsurance
• **Physician hospital services**	Subject to deductible and coinsurance
• **Other hospital services**	Subject to deductible and coinsurance
Infusion therapy	
• **Home infusion services** (when medically appropriate and provider available)	Subject to deductible and coinsurance
• **Outpatient services**	Subject to deductible and coinsurance
Maternity services	
• **Hospital services**	Subject to deductible and coinsurance
• **Physician services**	Subject to deductible and coinsurance
Mental health and substance use disorder services	
• **Outpatient care**	Subject to deductible and coinsurance
• **Transitional care**	Subject to deductible and coinsurance
Nutritional counseling	Subject to deductible and coinsurance
Outpatient laboratory services	Subject to deductible and coinsurance
Outpatient radiology services	Subject to deductible and coinsurance
Physician services	
• **Office visits**	Subject to deductible and coinsurance (Preventive exams covered at 100%)
• **Office visits with primary care physician (PCP)**	Subject to deductible and coinsurance (Preventive exams covered at 100%)
• **Office visits with specialist**	Subject to deductible and coinsurance

Your benefits	
• **Other physician services in an office**	Subject to deductible and coinsurance (Preventive immunizations covered at 100%)

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.	
• **Preventive exams** (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%
• **Abdominal aortic aneurysm (ultrasound) screening** (age 65 through 75)	Covered at 100% (Limited to 1 visit per lifetime)
• **Breast feeding support and counseling**	Covered at 100%
• **Cervical cancer screenings** (age 21 through 65)	
○ Human papillomavirus DNA screening (HPV)	1 every five years then subject to deductible and coinsurance
○ Pap smear screening	1 every three years then subject to deductible and coinsurance
• **Chlamydia screening**	1 per calendar year then subject to deductible and coinsurance
• **Colorectal cancer screenings**	
○ Colonoscopy screening (age 45 and older)	1 every five years then 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

Your benefits	
○ Sigmoidoscopy screening (age 45 and older)	1 every five years then 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

○ Other colorectal cancer screenings ~Fecal occult blood testing (age 45 and older)	1 per calendar year then subject to deductible and coinsurance
• **Gynecological examination** (breast exam and pelvic exam)	1 per calendar year then subject to deductible and coinsurance
• **Hearing screening** (under age 22)	1 per calendar year then subject to deductible and coinsurance
• **Immunizations and vaccinations** (including those needed for travel)	Covered at 100%
• **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 through 75)	1 per calendar year then subject to deductible and coinsurance
○ Diabetes Type 2 screening (age 35 through 70 with BMI 25+)	1 per calendar year then subject to deductible and coinsurance
○ Hemoglobin (A1C) (diabetics)	2 per calendar year then subject to deductible and coinsurance
○ Lead screening (age 1 through 6)	1 per calendar year then 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
• **Osteoporosis screening (bone density)** ○ Routine osteoporosis screening (age 65 and older) ○ Osteoporosis screening for personal or family history or at increased risk (under age 65)	1 every two years then subject to deductible and coinsurance
• **Prostate cancer screenings**	
○ Digital examination	Subject to deductible and coinsurance

Your benefits	
○ Prostate specific antigen test (PSA) (age 55 through 69)	1 per calendar year then subject to deductible and coinsurance
• **Vision screenings**	
○ Pediatric/adolescent vision screening (under age 19)	1 per calendar year then subject to deductible and coinsurance
Rehabilitative therapy	
• **Occupational therapy** ~*Requires prior authorization*	Subject to deductible and coinsurance

• **Physical therapy** *~Requires prior authorization*	Subject to deductible and coinsurance
• **Speech therapy** *~Requires prior authorization*	Subject to deductible and coinsurance
Skilled nursing facility *~Requires prior authorization*	Subject to deductible and coinsurance (Limited to 30 days per individual per confinement)
Surgical services	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)
Transplant services *~Requires prior authorization*	Subject to deductible and coinsurance
Urgent care services	
• **Urgent care office visits**	Subject to deductible and coinsurance
• **Other urgent care services**	Subject to deductible and coinsurance
Vision examinations	Subject to deductible and coinsurance

Pharmacy	
• 100% coverage for preventive prescription drugs (not subject to deductible, if applicable). 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.	Subject to deductible. After deductible, 20% coinsurance applies to covered prescription drugs until the maximum out-of-pocket is met. Benefit year - April 1 through March 31 Deductible, copayments and coinsurance may apply to the max out of pocket amounts.

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 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 Group #670019

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 of Benefits 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	
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.
Coinsurance	20%

Annual out-of-pocket (Deductible and coinsurance)	$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.
Dependent wrap coverage In addition to the benefits described in the Summary Plan Description, dependents living outside of the service area are provided benefits for covered services from out-of-network providers.	Such coverage shall be provided at the in-network level of benefits. Usual, Customary and Reasonable (UCR) fees may apply.

Your benefits	
Ambulance services	Subject to deductible and coinsurance
Anesthesia services	Subject to deductible and coinsurance
Breast cancer (BRCA 1 and 2) gene screening ~*Requires prior authorization*	Covered at 100% (Limited to 1 test per lifetime, or, if appropriate as determined by attending provider and meets medically necessity criteria)
Care My Way ®	Subject to deductible
Chiropractic services	Subject to deductible and coinsurance
Dry needling	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
• **Approved to be dispensed from a network pharmacy**	Refer to pharmacy benefit for pharmacy cost-share
Emergency services	
• **Emergency room facility**	Subject to deductible and coinsurance
• **Other emergency services**	Subject to deductible and coinsurance
Habilitative therapy	
• **Occupational therapy** ~*Requires prior authorization*	Subject to deductible and coinsurance
• **Physical therapy** ~*Requires prior authorization*	Subject to deductible and coinsurance

• **Speech therapy** *~Requires prior authorization*	Subject to deductible and coinsurance
Hearing examinations (diagnostic)	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)
Hospice care	Subject to deductible and coinsurance

Your benefits	
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
• **Inpatient/residential mental health and substance use disorder services** *~Requires prior authorization*	Subject to deductible and coinsurance
• **Outpatient hospital and surgical services** (not including emergency room)	Subject to deductible and coinsurance
• **Physician hospital services**	Subject to deductible and coinsurance
• **Other hospital services**	Subject to deductible and coinsurance
Infusion therapy	
• **Home infusion services** (when medically appropriate and provider available)	Subject to deductible and coinsurance
• **Outpatient services**	Subject to deductible and coinsurance
Maternity services	
• **Hospital services**	Subject to deductible and coinsurance
• **Physician services**	Subject to deductible and coinsurance
Mental health and substance use disorder services	
• **Outpatient care**	Subject to deductible and coinsurance
• **Transitional care**	Subject to deductible and coinsurance
Nutritional counseling	Subject to deductible and coinsurance
Outpatient laboratory services	Subject to deductible and coinsurance
Outpatient radiology services	Subject to deductible and coinsurance
Physician services	

• **Office visits**	Subject to deductible and coinsurance (Preventive exams covered at 100%)
• **Office visits with primary care physician (PCP)**	Subject to deductible and coinsurance (Preventive exams covered at 100%)
• **Office visits with specialist**	Subject to deductible and coinsurance

Your benefits	
• **Other physician services in an office**	Subject to deductible and coinsurance (Preventive immunizations covered at 100%)
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.	
• **Preventive exams** (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%
• **Abdominal aortic aneurysm (ultrasound) screening** (age 65 through 75)	Covered at 100% (Limited to 1 visit per lifetime)
• **Breast feeding support and counseling**	Covered at 100%
• **Cervical cancer screenings** (age 21 through 65)	
○ Human papillomavirus DNA screening (HPV)	1 every five years then subject to deductible and coinsurance
○ Pap smear screening	1 every three years then subject to deductible and coinsurance
• **Chlamydia screening**	1 per calendar year then subject to deductible and coinsurance
• **Colorectal cancer screenings**	

○ Colonoscopy screening (age 45 and older)	1 every five years then 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

Your benefits	
○ Sigmoidoscopy screening (age 45 and older)	1 every five years then 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
○ Other colorectal cancer screenings ~Fecal occult blood testing (age 45 and older)	1 per calendar year then subject to deductible and coinsurance
• **Gynecological examination** (breast exam and pelvic exam)	1 per calendar year then subject to deductible and coinsurance
• **Hearing screening** (under age 22)	1 per calendar year then subject to deductible and coinsurance
• **Immunizations and vaccinations** (including those needed for travel)	Covered at 100%
• **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 through 75)	1 per calendar year then subject to deductible and coinsurance
○ Diabetes Type 2 screening (age 35 through 70 with BMI 25+)	1 per calendar year then subject to deductible and coinsurance
○ Hemoglobin (A1C) (diabetics)	2 per calendar year then subject to deductible and coinsurance
○ Lead screening (age 1 through 6)	1 per calendar year then 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
• **Osteoporosis screening (bone density)** ○ Routine osteoporosis screening (age 65 and older) ○ Osteoporosis screening for personal or family history or at increased risk (under age 65)	1 every two years then subject to deductible and coinsurance
• **Prostate cancer screenings**	
○ Digital examination	Subject to deductible and coinsurance

Your benefits	
○ Prostate specific antigen test (PSA) (age 55 through 69)	1 per calendar year then subject to deductible and coinsurance
• **Vision screenings**	
○ Pediatric/adolescent vision screening (under age 19)	1 per calendar year then subject to deductible and coinsurance
Rehabilitative therapy	
• **Occupational therapy** *~Requires prior authorization*	Subject to deductible and coinsurance
• **Physical therapy** *~Requires prior authorization*	Subject to deductible and coinsurance
• **Speech therapy** *~Requires prior authorization*	Subject to deductible and coinsurance
Skilled nursing facility *~Requires prior authorization*	Subject to deductible and coinsurance (Limited to 30 days per individual per confinement)
Surgical services	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)
Transplant services *~Requires prior authorization*	Subject to deductible and coinsurance
Urgent care services	
• **Urgent care office visits**	Subject to deductible and coinsurance
• **Other urgent care services**	Subject to deductible and coinsurance
Vision examinations	Subject to deductible and coinsurance

Pharmacy	
• 100% coverage for preventive prescription drugs (not subject to deductible, if applicable). 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.	Subject to deductible. After deductible, 20% coinsurance applies to covered prescription drugs until the maximum out-of-pocket is met. Benefit year - April 1 through March 31 Deductible, copayments and coinsurance may apply to the max out of pocket amounts.

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 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 – Explore HMO HDHP Group #670024

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 of Benefits 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	
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.
Coinsurance	20%

Annual out-of-pocket (Deductible and coinsurance)	$5,000 per individual $10,000 per family The family annual out of pocket can be met by any combination of members within a family. If one family member meets the individual annual out of pocket, the annual out of pocket is satisfied for his or her claims. The maximum annual out of pocket is equal to the family annual out of pocket.

Your benefits	
Ambulance services	Subject to deductible and coinsurance
Anesthesia services	Subject to deductible and coinsurance
Breast cancer (BRCA 1 and 2) gene screening *~Requires prior authorization*	Covered at 100% (Limited to 1 test per lifetime, or, if appropriate as determined by attending provider and meets medically necessity criteria)
Care My Way ®	Subject to deductible
Chiropractic services	Subject to deductible and coinsurance

Your benefits	
Dry needling	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
• **Approved to be dispensed from a network pharmacy**	Refer to pharmacy benefit for pharmacy cost-share
Emergency services	
• **Emergency room facility**	Subject to deductible and coinsurance
• **Other emergency services**	Subject to deductible and coinsurance
Habilitative therapy	
• **Occupational therapy** *~Requires prior authorization*	Subject to deductible and coinsurance
• **Physical therapy** *~Requires prior authorization*	Subject to deductible and coinsurance
• **Speech therapy** *~Requires prior authorization*	Subject to deductible and coinsurance
Hearing examinations (diagnostic)	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)
Hospice care	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
• **Inpatient/residential mental health and substance use disorder services** *~Requires prior authorization*	Subject to deductible and coinsurance
• **Outpatient hospital and surgical services** (not including emergency room)	Subject to deductible and coinsurance
• **Physician hospital services**	Subject to deductible and coinsurance

Your benefits	
• **Other hospital services**	Subject to deductible and coinsurance
Infusion therapy	
• **Home infusion services** (when medically appropriate and provider available)	Subject to deductible and coinsurance
• **Outpatient services**	Subject to deductible and coinsurance
Maternity services	
• **Hospital services**	Subject to deductible and coinsurance
• **Physician services**	Subject to deductible and coinsurance
Mental health and substance use disorder services	
• **Outpatient care**	Subject to deductible and coinsurance
• **Transitional care**	Subject to deductible and coinsurance
Nutritional counseling	Subject to deductible and coinsurance
Outpatient laboratory services	Subject to deductible and coinsurance
Outpatient radiology services	Subject to deductible and coinsurance
Physician services	
• **Office visits**	Subject to deductible and coinsurance (Preventive exams covered at 100%)
• **Office visits with primary care physician (PCP)**	Subject to deductible and coinsurance (Preventive exams covered at 100%)

• **Office visits with specialist**	Subject to deductible and coinsurance
• **Other physician services in an office**	Subject to deductible and coinsurance (Preventive immunizations covered at 100%)

Your benefits	
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.	
• **Preventive exams** (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%
• **Abdominal aortic aneurysm (ultrasound) screening** (age 65 through 75)	Covered at 100% (Limited to 1 visit per lifetime)
• **Breast feeding support and counseling**	Covered at 100%
• **Cervical cancer screenings** (age 21 through 65)	
○ Human papillomavirus DNA screening (HPV)	1 every five years then subject to deductible and coinsurance
○ Pap smear screening	1 every three years then subject to deductible and coinsurance
• **Chlamydia screening**	1 per calendar year then subject to deductible and coinsurance
• **Colorectal cancer screenings**	
○ Colonoscopy screening (age 45 and older)	1 every five years then 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
○ Sigmoidoscopy screening (age 45 and older)	1 every five years then subject to deductible and coinsurance

Your benefits	
○ Sigmoidoscopy screening for personal or family history of polyps or colorectal cancer	1 every two years then 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
• **Gynecological examination** (breast exam and pelvic exam)	1 per calendar year then subject to deductible and coinsurance
• **Hearing screening** (under age 22)	1 per calendar year then subject to deductible and coinsurance
• **Immunizations and vaccinations** (including those needed for travel)	Covered at 100%
• **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 through 75)	1 per calendar year then subject to deductible and coinsurance
○ Diabetes Type 2 screening (age 35 through 70 with BMI 25+)	1 per calendar year then subject to deductible and coinsurance
○ Hemoglobin (A1C) (diabetics)	2 per calendar year then subject to deductible and coinsurance
○ Lead screening (age 1 through 6)	1 per calendar year then 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
• **Osteoporosis screening (bone density)** ○ Routine osteoporosis screening (age 65 and older) ○ Osteoporosis screening for personal or family history or at increased risk (under age 65)	1 every two years then subject to deductible and coinsurance
• **Prostate cancer screenings**	
○ Digital examination	Subject to deductible and coinsurance
○ Prostate specific antigen test (PSA) (age 55 through 69)	1 per calendar year then subject to deductible and coinsurance

Your benefits	
• **Vision screenings**	
○ Pediatric/adolescent vision screening (under age 19)	1 per calendar year then subject to deductible and coinsurance

Rehabilitative therapy	
• **Occupational therapy** *~Requires prior authorization*	Subject to deductible and coinsurance
• **Physical therapy** *~Requires prior authorization*	Subject to deductible and coinsurance
• **Speech therapy** *~Requires prior authorization*	Subject to deductible and coinsurance
Skilled nursing facility *~Requires prior authorization*	Subject to deductible and coinsurance (Limited to 30 days per individual per confinement)
Surgical services	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)
Transplant services *~Requires prior authorization*	Subject to deductible and coinsurance
Urgent care services	
• **Urgent care office visits**	Subject to deductible and coinsurance
• **Other urgent care services**	Subject to deductible and coinsurance
Vision examinations	Subject to deductible and coinsurance

Pharmacy	
• 100% coverage for preventive prescription drugs (not subject to deductible, if applicable). 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.	Subject to deductible. After deductible, 20% coinsurance applies to covered prescription drugs until the maximum out-of-pocket is met. Benefit year - April 1 through March 31 Deductible, copayments and coinsurance may apply to the max out of pocket amounts.

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 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 – Active Advantage J1 Visa Group #

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 of Benefits 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	$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 and 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 and 2) gene screening ~*Requires prior authorization*	Covered at 100% (Limited to 1 test per lifetime, or, if appropriate as determined by attending provider and meets medically necessity criteria)	Subject to deductible and coinsurance (Limited to 1 test per lifetime, or, if appropriate as determined by attending provider and meets medically necessity criteria)
Care My Way ®	Covered at 100%	Not applicable
Chiropractic services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Chronic care management		
• **Asthma care management**	Office visits with your asthma care provider are limited to 4 visits per individual per benefit year then subject to deductible and coinsurance Unlimited spirometry services Unlimited asthma care kits Unlimited peak flow meters Unlimited spacers Asthma medications identified on the asthma medications list for members in the asthma disease management program are covered at 100%	Subject to deductible and coinsurance

Your benefits	In-network	Out-of-network
• **Diabetes care management**	Office visits with your diabetes care provider are limited to 4 visits per individual per benefit year then subject to deductible and coinsurance Unlimited services for diabetes outpatient self-management education Medical nutrition therapy services are limited to 4 visits with a registered dietician per individual per benefit year (refer to Summary Plan Description) Vision examinations are limited to 1 examination per individual per benefit year The following lab services are covered 100% when accompanied with a diabetes diagnosis: urine albumin/microalbumin, urine protein, urinalysis, hemoglobin A1C, lipid panel, lipoprotein and/or triglycerides	Subject to deductible and coinsurance
• **High cholesterol care management**	The following lab services are covered at 100%: lipid panel, lipoprotein or triglycerides	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)

Your benefits	In-network	Out-of-network

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
Emergency services		
• **Emergency room facility** (Copayment waived if admitted to hospital as inpatient)	$200 copayment per visit Balance of charge after copayment applies to annual deductible and coinsurance. Copayments continue 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.
• **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
Your benefits	**In-network**	**Out-of-network**
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
• **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

Your benefits	**In-network**	**Out-of-network**
Outpatient laboratory services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Outpatient radiology services	Subject to deductible and coinsurance	Subject to deductible and coinsurance

Physician services		
• **Office visits**	Subject to deductible and coinsurance (Preventive exams covered at 100%)	Subject to deductible and coinsurance
• **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
• **Office visits with specialist**	Subject to deductible and coinsurance	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

Your benefits	In-network	Out-of-network
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.		
• **Preventive exams** (comprehensive physical examination) o Well-baby care o Well-child care o Well-adolescent care o Well-adult care o Interpersonal and domestic violence screening o Nutritional screening o Screening and counseling for sexually transmitted infections	Covered at 100%	Subject to deductible and coinsurance

• **Abdominal aortic aneurysm (ultrasound) screening** (age 65 through 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 through 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

Your benefits	**In-network**	**Out-of-network**
• **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
• **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 through 75)	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
○ Diabetes Type 2 screening (age 35 through 70 with BMI 25+)	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 through 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 density)** ○ Routine osteoporosis screening (age 65 and older) ○ Osteoporosis screening for personal or family history or at increased risk (under age 65)	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 through 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)

Your benefits	**In-network**	**Out-of-network**
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**	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	

• 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 Diabetic list (Not subject to deductible, if applicable.) • 100% coverage for insulin and diabetic testing supplies included on the Diabetic list (Not subject to deductible, if applicable.) • Diabetic prescription drugs, testing supplies and insulin not included on the Diabetic 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. $30 copayment per tier 2 prescription or refill. $60 copayment per tier 3 prescription or refill. 25% coinsurance per TIER 4 prescription or refill (specialty prescription drugs). The following benefit applies when filled at any NON MARSHFIELD CLINIC PHARMACY: $10 copayment per tier 1 prescription or refill. $50 copayment per tier 2 prescription or refill. Tier 3 drugs-member pays the greater of $100 or 50% of the cost of prescriptions. No coverage for tier 4 prescriptions (specialty medications) unless filled at any Marshfield Clinic Pharmacy location. For limited distribution drugs which are only available through select pharmacies, 25% coinsurance will be assessed. Deductible, copayments and coinsurance may apply to the max out of pocket amounts.

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 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

The section entitled MEDICAL BENEFITS; Habilitative Services Therapies benefit has been removed and replaced with the following:

Habilitative Services and Therapies. These services include:

1. **Applied Behavior Analysis (ABA) Therapy.** Charges for ABA therapy.
2. **Occupational Therapy.** Treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing outpatient facility.
3. **Physical Therapy.** Treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed outpatient therapy facility.
4. **Speech-Language Pathology.** Treatment for speech delays and disorders.

The section entitled MEDICAL BENEFITS; Nutritional Counseling benefit has been removed and replaced with the following:

Nutritional Counseling. Charges for nutritional counseling for the management of a medical condition (including both physical and mental health conditions).

The section entitled HIPAA PRIVACY; the following is added:

Reproductive Health Information

Pursuant to federal law (29 FR 32976), unless required by law, the Plan will **not** use or disclose PHI which is requested to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for either purpose.

If the Plan receives a request for PHI which is potentially related to reproductive health care for one of these impermissible purposes, the Plan will not use or disclose PHI without first obtaining a signed attestation from the requesting party that the request is not for an impermissible purpose.

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

Marshfield Clinic Health System, Inc.

By: Terri Newmier

Name: Terri Newmier

Date: April 11, 2025

Title: Chief Human Resources Officer, Mfld