Schedule of Benefits – Enrich HMO HDHP Plus

Group - 670019 - MARSHFIELD CLINIC HEALTH SYSTEM
Benefit Year: April 1 through March 31
Effective Date: 04/01/2025

SecurityHealth Plan℠
Security Administrative Services

Security Administrative Services shows that you and any covered dependents have coverage as described in your Summary Plan Description and Schedule of Benefits as of the effective date shown on the letter you received with your identification cards, subject to the terms, conditions, exclusions, limitations and all other provisions of the Summary Plan Description.

This Schedule 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

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

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

Limited English Proficiency Language Services
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-877-509-1952 (TTY 711). ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-509-1952 (TTY 711). LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-509-1952 (TTY 711). If you require materials in large print, please call 1-877-509-1952 (TTY 711).