This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.sastpa.com
For general definitions of common terms, such as **allowed amount**, **balance billing,** **coinsurance**, **copayment**, **deductible**, **provider**, or other **bolded** terms see the **Glossary**. You can view the Glossary at **www.sastpa.com** or call 1-800-550-4115 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In Network** **$1,500** person or **$3,000** family. **Non Network** **$3,000** person or **$6,000** family.	You must pay all the costs up to the **deductible** amount before this **plan** begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1). The Common Medical Events chart below shows how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No. There are no other specific **deductibles**.	You must pay all of the costs for services up to the specific **deductible** amount before this **plan** begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For participating **providers** **$1,500**/person or **$3,000**/family For non-participating **providers** **$3,000**/person or **$6,000**/family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	**Premiums**, balance-billed charges, co-pays, health care this **plan** doesn't cover, [and out-of-network services].	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See **www.sastpa.com** for a list of participating **providers**.	If you use an in-network health care **provider**, this **plan** will pay some or all of the costs of covered services. Lesser coverage, or no coverage, may be available for out-of-network **providers**. Be aware, your in-network doctor or hospital may use another out-of-network **provider** for some services (such as lab work).
Do I need a referral to see a specialist?	No. To see a **specialist**, you don't need a **referral** from this **plan**.	You can see the **specialist** you choose without getting permission from this **plan**.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 after deductible	$0 after deductible	Deductible applies
	Specialist visit	$0 after deductible	$0 after deductible	
	Other practitioner office visit	$0 after deductible	$0 after deductible	
	Preventive care/**screening**/immunization	$0 after deductible	$0 after deductible	
If you have a test	**Diagnostic test** (x-ray, blood work)	$0 after deductible	$0 after deductible	Deductible applies
	Imaging (CT/PET scans, MRIs)	$0 after deductible	$0 after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.sastpa.com	Generic drugs	$4 copay retail and $10 mail order	N/A	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	$20 copay retail and $50 mail order	N/A	————————none————————
	Non-preferred brand drugs	$40 copay retail and $100 mail order	N/A	
	Specialty drugs	Refer to Plan	Refer to Plan	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0 no deductible	$0 no deductible	Deductible applies. Pre-Certification required
	Physician/surgeon fees	$0 no deductible	$0 no deductible	
If you need immediate medical attention	Emergency room services	$0 after deductible	$0 after deductible	Deductible applies
	Emergency medical transportation	$0 after deductible	$0 after deductible	
	Urgent care	$0 after deductible	$0 after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	$0 after deductible	$0 after deductible	Deductible applies. Pre-Certification required
	Physician/surgeon fees	$0 after deductible	$0 after deductible	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$0 after deductible	$0 after deductible	Deductible applies
	Mental/Behavioral health inpatient services	$0 after deductible	$0 after deductible	
	Substance use disorder outpatient services	$0 after deductible	$0 after deductible	
	Substance use disorder inpatient services	$0 after deductible	$0 after deductible	
If you are pregnant	Prenatal, postnatal care, delivery, and all inpatient services	$0 after deductible	$0 after deductible	Deductible applies

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$0 after deductible	$0 after deductible	Deductible applies. Refer to Plan document for limitations/exceptions
	Rehabilitation services	$0 after deductible	$0 after deductible	
	Habilitation services	$0 after deductible	$0 after deductible	
	Skilled nursing care	$0 after deductible	$0 after deductible	
	Durable medical equipment	$0 after deductible	$0 after deductible	
	Hospice services	$0 after deductible	$0 after deductible	
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine Foot care
- Weight Loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Allergy testing
- Chemotherapy
- Chiropractic care
- Most coverage provided outside the United States. See www.sastpa.com
- Smoking cessation

Your Rights to Continue Coverage: Federal and State laws may provide protections that allow you to continue health coverage after it would otherwise end. For more information, contact us at 1-800-550-4115 or contact: 1-317-232-2385. Other options to continue coverage are available to you too, including individual insurance coverage through the Health Insurance Marketplace. For more information about the **Marketplace**, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for **claims** under your **plan**, you may be able to **appeal** or file a **grievance**. For more information about your rights, this notice, or assistance, contact: 1-800-550-4115.

Does this Coverage Satisfy the Individual Responsibility Requirement and Meet the Minimum Value Standard?

Yes. This coverage constitutes **minimum essential coverage** under the Affordable Care Act, so enrolling in this coverage satisfies your obligations under the **individual responsibility requirement**. In addition, this coverage provides a level of benefits specified in the Affordable Care Act as "minimum value."

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

Notice of Nondiscrimination

Security Health Plan of Wisconsin, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Limited English Proficiency Language Services

[Spanish] ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-472-2363 (TTY: 711).

[Hmong] LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-472-2363 (TTY: 711).

About these Coverage Examples:

These examples show how this **plan** might cover medical care in a few situations and show how **deductibles**, **copayments**, and **coinsurance** can add up. Use these examples to see, in general, how much financial protection a sample patient might get from coverage under this plan compared to other plans by comparing the "Patient Pays" section for the same example under each plan's Summary of Benefits and Coverage.

This is not a cost estimator. Don't use these examples to estimate your actual costs under this **plan**. Treatments shown are just examples and your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Also, costs don't include **premiums** you pay to buy coverage under a plan.

Having a baby
(normal delivery)

- **Cost of care** $14,150
- **Plan pays** $12,650
- **Patient pays** $1,500

Sample care costs:

Hospital charges (mother)	$6,700
Routine obstetric care	$2,500
Hospital charges (baby)	$2,100
Anesthesia	$1,200
Laboratory tests	$1,000
Prescriptions	$200
Radiology	$200
Education	$200
Vaccines, other preventive	$50
Total	**$14,150**

Patient pays:

Deductibles	$1500
Copayments	$
Coinsurance	$
Limits or exclusions	$0
Total	**$1500**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Cost of care** $6,100
- **Plan pays** $4,520
- **Patient pays** $1,580

Sample care costs:

Prescriptions	$3,300
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$800
Education	$300
Laboratory tests	$200
Vaccines, other preventive	$200
Total	**$6,100**

Patient pays:

Deductibles	$1500
Copayments	$
Coinsurance	$
Limits or exclusions	$80
Total	**$1580**

Simple fracture
(with emergency room visit)

- **Cost of care** $2,400
- **Plan pays** $890
- **Patient pays** $1,510

Sample care costs:

Emergency Services	$1,400
Medical Equipment and Supplies	$400
Office Visits and Procedures	$300
Physical Therapy	$200
Laboratory tests	$90
Prescriptions	$10
Total	**$2,400**

Patient pays:

Deductibles	$1500
Copayments	$
Coinsurance	$
Limits or exclusions	$10
Total	**$1510**