
 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-570-8760 or visit www.sastpa.com. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbcglossary> or call 1-800-570-8760 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$1,500 individual / \$3,000 family In network \$2,500 individual / \$5,000 family Out-of-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. Preventive care are covered before you meet your deductible	This plan covers some items and services even if you haven't yet met the deductible amount. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible with in network providers.
Are there other deductibles for specific services?	There are no other specific deductibles .	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$6,400 individual/\$12,900 family in network \$8,900 individual/\$17,900 family Out-of-network	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , the overall family out-of-pocket limits must be met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network providers ?	Yes. See www.sastpa.com or call 1-800-570-8760 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	None
	Specialist visit	10% coinsurance	30% coinsurance	None
	Preventive care/screening/immunization	No charge	No charge	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.sastpa.com or call Pharmacy Services at 1-877-873-5611	Tier 1 – Preferred generic drugs	10% coinsurance	If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment/coinsurance amount.	Deductible and Out-of-pocket limit applies Limited to a 100 day supply If the participant requests the brand name prescription drug where a generic is available, the participant must pay the applicable generic copayment/coinsurance plus the ancillary charge. The ancillary charge is the cost difference between the brand name prescription drug and the generic prescription drug. The ancillary charge will not count towards the prescription out-of-pocket limit .
	Tier 2 - Preferred brand drugs and select non-preferred generic drugs	10% coinsurance		
	Tier 3 - Non preferred brand drugs and select non-preferred generic drugs	10% coinsurance		
	Tier 4 - Specialty drugs	10% coinsurance		

Questions: Call 1-800-570-8760 or visit us at www.sastpa.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Precertification is required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Precertification is required.
If you need immediate medical attention	Emergency room care	\$100 copay /visit then 10% coinsurance	\$100 copay /visit then 10% coinsurance	Network deductible applies on out of network providers . When a bill for hospitalization or ER occurs subsequent to declining case management, the first \$300 will not be considered for benefit payments. The balance would be considered subject to plan provisions.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Network deductible applies out of network providers .
	Urgent care	10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Precertification is required. When a bill for hospitalization or ER occurs subsequent to declining case management, the first \$300 will not be considered for benefit payments. The balance would be considered subject to plan provisions.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	None
	Inpatient services	10% coinsurance	30% coinsurance	Precertification is required.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	None
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Limited to 100 visits per 12 month period.
	Rehabilitation services	10% coinsurance	30% coinsurance	Precertification is required after 15 visits.
	Habilitation services	Not covered	Not covered	Habilitation services are generally not covered.
	Skilled nursing care	10% coinsurance	30% coinsurance	Limited to 100 days per disability. Precertification is required.
	Durable medical equipment	10% coinsurance	30% coinsurance	None
	Hospice services	10% coinsurance	30% coinsurance	Home Hospice: Limited to 80 visits per 6 month period Inpatient Hospice: Limited to 30 days per calendar year.
If your child needs dental or eye care	Children's eye exam	0% coinsurance	30% coinsurance	Limited to one exam per calendar year. Network preventive care not subject to deductible .
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	0% coinsurance	30% coinsurance	One preventive exam every 180 days. Network preventive care is not subject to deductible

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

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|--|---|---|
| <ul style="list-style-type: none"> • Acupuncture • Cosmetic Surgery • Dental Care (Adult) | <ul style="list-style-type: none"> • Hearing aids (Adult) • Infertility treatment • Long-term care | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the US • Routine foot care (except for certain conditions) • Weight Loss Programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric Surgery
- Chiropractic Care
- Private Duty Nursing
- Routine Eye Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is your state insurance department, of the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying 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: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Security Administrative Services LLC, 1515 Saint Joseph Ave., Marshfield, WI or at 1-715-221-9733 or 1-800-570-8760. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-855-247-8962.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-247-8962.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-247-8962.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-247-8962.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and excluded services under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$1,500
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (ultrasounds and blood work)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$2,500

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1,500
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$590
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,090

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$1,500
■ Specialist coinsurance	10%
■ Hospital (facility) copayment	\$100
■ Other coinsurance	10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$100
Coinsurance	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,630