



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, visit Join.Surest.com, Surest mobile app or call Surest Member Services at 1-866-683-6440. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at Healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive Care</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copay</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at Healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network providers</u> : \$5,000 individual / \$10,000 family For <u>out-of-network providers</u> : Not applicable	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See Join.Surest.com or call 1-866-683-6440 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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*
		In-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	\$20 - \$105 <u>copay</u> /visit	Not covered	<p>Certain procedures performed in the office may have a higher office visit <u>copay</u>. <u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p>*Cost share applies to any other Telehealth service based on <u>provider</u> type. If you receive services in addition to office visit, additional <u>copays</u> may apply.</p> <p>You may have to pay for services that are not <u>preventive</u>. Ask your <u>provider</u> if the services needed are <u>preventive</u>. Then check what your <u>plan</u> will pay for.</p>
	<u>Specialist</u> visit	\$20 - \$105 <u>copay</u> /visit	Not covered	
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	
If you have a test	Routine <u>diagnostic test</u> (e.g., x-ray, blood work) Non-routine <u>diagnostic test</u> (e.g., sleep study, genetic testing)	Routine <u>diagnostic test</u> : No charge Non-routine <u>diagnostic test</u> : \$20 - \$1,050 <u>copay</u> /visit	Routine <u>diagnostic test</u> : No charge Non-routine <u>diagnostic test</u> : Not covered	<p><u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p><u>Prior authorization</u> is required for certain Non-routine <u>diagnostic tests</u> or there may be no coverage.</p>
	Imaging (CT/PET scans, MRIs)	\$125 - \$1,400 <u>copay</u> /visit	Not covered	<p><u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p><u>Prior authorization</u> is required for certain imaging tests or there may be no coverage.</p>

*For more information about limitations and exceptions, see the plan or policy document at Join.Surest.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at Optumrx.com.</p>	Preventive Pharmacy	Up to 90-Day Supply No charge	Not covered	<p>Certain Tier 1 drugs are available with no charge, including prescribed generic contraceptives and tobacco cessation medications.</p> <p>To learn more about drug tiers and about copays for specific drugs, visit Optumrx.com website.</p> <p>Prior authorization is required for certain drugs or there may be no coverage.</p>
	Tier 1 drugs	Up to 31-Day Supply \$10 copay	Not covered	
		Up to 90-Day Supply \$25 copay	Not covered	
	Tier 2 drugs	Up to 31-Day Supply \$60 copay	Not covered	
		Up to 90-Day Supply \$150 copay		
	Tier 3 drugs	Up to 31-Day Supply \$90 copay	Not covered	
Up to 90-Day Supply \$225 copay				
<u>Specialty drugs</u>	Up to 31-Day Supply Tier 1: \$240 copay Tier 2: \$270 copay Tier 3: \$300 copay	Not covered	<p>Specialty drugs are not covered at a 90-day supply.</p> <p>Prior authorization is required for certain specialty drugs or there may be no coverage.</p>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-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)	\$35 - \$3,000 <u>copay/visit</u>	Not covered	<p><u>Copays</u> are listed as a range. <u>Providers</u> are assigned copays within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p><u>Prior authorization</u> is required for certain outpatient surgery or there may be no coverage.</p>
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	<u>Emergency room care</u>	\$600 <u>copay/visit</u>	\$600 <u>copay/visit</u>	<p><u>Copay</u> is waived if admitted within 24 hours. <u>Out-of-network emergency room care visit copay</u> applies to the <u>in-network out-of-pocket limit</u>.</p> <p><u>Prior authorization</u> is required for non-emergency medical transportation or there may be no coverage. <u>Out-of-network emergency medical transportation copay</u> applies to the <u>in-network out-of-pocket limit</u>.</p>
	<u>Emergency medical transportation</u>	\$350 <u>copay/transport</u>	\$350 <u>copay/transport</u>	
	<u>Urgent care</u>	\$60 <u>copay/visit</u>	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 - \$3,000 <u>copay/stay</u>	Not covered	<p><u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p><u>Prior authorization</u> is required for non-emergency facility admissions and inpatient surgery or there may be no coverage.</p>
	Physician/surgeon fees	No charge	Not covered	

*For more information about limitations and exceptions, see the plan or policy document at Join.Surest.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Home/Office: \$20 <u>copay/visit</u> Outpatient Facility: \$130 <u>copay/visit</u>	Not covered	Certain procedures/services in the outpatient setting may have a lower <u>copay</u> . <u>Prior authorization</u> is required for certain outpatient services or there may be no coverage.
	Inpatient services	\$2,000 <u>copay/stay</u>	Not covered	Certain procedures/services in the inpatient setting may have a lower <u>copay</u> . <u>Prior authorization</u> is required for certain inpatient services or there may be no coverage.
If you are pregnant	Office visits	No charge	Not covered	<u>Cost sharing</u> does not apply to <u>preventive services</u> with <u>network providers</u> . Depending on the type of service, a <u>copay</u> may apply.
	Childbirth/delivery professional services	No charge	Not covered	One <u>copay</u> for all covered services related to childbirth/delivery, including the newborn, unless discharged after mother.
	Childbirth/delivery facility services	\$900 - \$2,000 <u>copay/stay</u>	Not covered	<u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care. <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . <u>Prior authorization</u> is required for inpatient stays beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery or there may be no coverage.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$60 <u>copay</u> /visit	Not covered	120 visit limit per person per <u>plan</u> year. <u>Prior authorization</u> is required for certain <u>home health care</u> services or there may be no coverage.
	<u>Rehabilitation services</u>	\$10 - \$130 <u>copay</u> /visit	Not covered	25 visit limit for occupational therapy 25 visit limit for physical therapy 25 visit limit for speech therapy Visit limits are per person per <u>plan</u> year.
	<u>Habilitation services</u>	\$10 - \$130 <u>copay</u> /visit	Not covered	<u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.
	<u>Skilled nursing care</u>	\$1,500 <u>copay</u> /stay	Not covered	120 day limit per person per <u>plan</u> year. <u>Prior authorization</u> is required or there may be no coverage.
	<u>Durable medical equipment</u>	\$0 - \$1,000 <u>copay</u> /equipment based on <u>DME</u> tier	Not covered	<u>Prior authorization</u> is required for certain <u>DME</u> or there may be no coverage.
	<u>Hospice services</u>	Home: \$60 <u>copay</u> /visit Inpatient: \$2,000 <u>copay</u> /stay	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

*For more information about limitations and exceptions, see the plan or policy document at Join.Surest.com.

Excluded Services & Other Covered Services:

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

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (20 visit limit per person per plan year)
- Chiropractic care (20 visit limit per person per plan year)
- Hearing aids (limitations apply)
- Routine foot care (for certain conditions)

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: the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/healthreform. You may also contact Surest Member Services at 1-866-683-6440. 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 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 on how 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: Surest Member Services at 1-866-683-6440, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

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 [1-866-633-2446].

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 [1-866-633-2446].

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [1-866-633-2446].

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf [1-866-633-2446] uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-866-633-2446].

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni [1-866-633-2446].

Carolinian (Kapasal Falawasch): ngere aukke ghut allis reel kapasal Falawasch au fafaingi tilifon ye [1-866-633-2446].

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang [1-866-633-2446].

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 \$0
- Specialist copayment \$20 - \$105
- Hospital (facility) copayment \$200 - \$3,000
- Other coinsurance \$0

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 \$12,700

In this example, Peg would pay:

Cost sharing

<u>Deductibles</u>	\$0
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is \$960

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$0
- Specialist copayment \$20 - \$105
- Hospital (facility) copayment \$200 - \$3,000
- Other coinsurance \$0

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 \$5,600

In this example, Joe would pay:

Cost sharing

<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,400
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$0
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The total Joe would pay is \$1,400

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$0
- Specialist copayment \$20 - \$105
- Hospital (facility) copayment \$200 - \$3,000
- Other coinsurance \$0

This EXAMPLE event includes services like:

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

Total Example Cost \$2,800

In this example, Mia would pay:

Cost sharing

<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is \$1,100

The plan would be responsible for the other costs of these EXAMPLE covered services.