
 **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](https://www.join.surest.com) or by calling Surest Member Services at 1-866-683-6440. 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 [www.healthcare.gov/sbc-glossary](https://www.healthcare.gov/sbc-glossary) or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters
<b>What is the overall deductible?</b>	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
<b>Are there services covered before you meet your deductible?</b>	Yes. This <u>plan</u> does not have a <u>deductible</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 <u>plan</u> covers certain <u>preventive services</u> without cost sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	For <u>network providers</u> : \$4,000 Individual / \$8,000 Family For <u>out-of-network providers</u> : \$8,000 Individual / \$16,000 Family	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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>preauthorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="https://www.join.surest.com">Join.Surest.com</a> , 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30 - \$125 <u>copay</u> / visit	\$215 <u>copay</u> / visit	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. Office Visit 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.
	<u>Specialist</u> visit	\$30 - \$125 <u>copay</u> / visit	\$215 <u>copay</u> / visit	
	<u>Preventive care/ screening/ immunization</u>	No Charge	\$190 <u>copay</u> / visit	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Routine <u>diagnostic test</u> : No Charge Non-routine <u>diagnostic test</u> : \$25 - \$1,250 <u>copay</u> / visit	Routine <u>diagnostic test</u> : No Charge Non-routine <u>diagnostic test</u> : Up to \$2,700 <u>copay</u> / visit	<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>Preauthorization</u> required for certain services for <u>out-of-network</u> or there is no coverage.
	Imaging (CT/PET scans, MRIs)	\$150 - \$1,050 <u>copay</u> / visit	Up to \$1,650 <u>copay</u> / visit	

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)	
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://Optumrx.com">Optumrx.com</a>	Tier 1 (Generic drugs)	30-Day Supply \$10 <u>copay</u>	30-Day Supply \$10 <u>copay</u>	Certain Tier 1 drugs are available with \$0 <u>copays</u> , including prescribed generic contraceptives and tobacco cessation medications.  To learn more about drug tiers and about <u>copays</u> for specific drugs, visit <a href="http://Optumrx.com">Optumrx.com</a> .  <u>Preauthorization</u> is required for certain drugs or may result in a higher cost.
		90-Day Supply \$25 <u>copay</u>	90-Day Supply \$25 <u>copay</u>	
	Tier 2 (Preferred brand drugs)	30-Day Supply \$60 <u>copay</u>	30-Day Supply \$60 <u>copay</u>	
		90-Day Supply \$150 <u>copay</u>	90-Day Supply \$150 <u>copay</u>	
	Tier 3 (Non-preferred brand drugs)	30-Day Supply \$90 <u>copay</u>	30-Day Supply \$90 <u>copay</u>	
90-Day Supply \$225 <u>copay</u>		90-Day Supply \$225 <u>copay</u>		
<u>Specialty drugs</u>	30-Day Supply Tier 1: \$10 <u>copay</u> Tier 2: \$150 <u>copay</u> Tier 3: \$300 <u>copay</u>	30-Day Supply Tier 1: \$10 <u>copay</u> Tier 2: \$150 <u>copay</u> Tier 3: \$300 <u>copay</u>	<u>Specialty drugs</u> are not covered at a 90-day supply.  <u>Preauthorization</u> is required for certain <u>specialty drugs</u> or may result in a higher cost.	

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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$50 - \$3500 <u>copay</u> / visit	Up to \$7000 <u>copay</u> / visit	<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>Preauthorization</u> required for certain services for <u>out-of-network</u> or there is no coverage.</p>
	Physician/surgeon fees	No Charge	No Charge	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$850 <u>copay</u> / visit	\$850 <u>copay</u> / visit	<p><u>Copay</u> is waived if admitted within 24 hours. Out-of-network <u>emergency room care</u> visit <u>copay</u> applies to the in-network <u>out-of-pocket</u> limit.</p>
	<u>Emergency medical transportation</u>	\$550 <u>copay</u> / transport	\$550 <u>copay</u> / transport	<p>Out-of-network <u>emergency medical transportation</u> <u>copay</u> applies to the in-network <u>out-of-pocket</u> limit.</p>
	<u>Urgent care</u>	\$80 <u>copay</u> / visit	\$200 <u>copay</u> / visit	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$200 - \$3,500 <u>copay</u> / stay	Up to \$7000 <u>copay</u> / stay	<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>Preauthorization</u> required for certain services for <u>out-of-network</u> or there is no coverage.</p>
	Physician/surgeon fees	No Charge	No Charge	

\*For more information about limitations and exceptions, see plan or policy document at [Join.Surest.com](http://Join.Surest.com) for prospective members.

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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Home/Office: \$30 <u>copay</u> / visit Outpatient Facility: \$160 <u>copay</u> / visit	Home/Office: \$190 <u>copay</u> / visit Outpatient Facility: \$480 <u>copay</u> / visit	Certain procedures/services in the outpatient setting may have a lower <u>copay</u> . <u>Preauthorization</u> required for certain services for <u>out-of-network</u> or there is no coverage.
	Inpatient services	\$2,750 <u>copay</u> / stay	\$7,000 <u>copay</u> / stay	Certain procedures/services in the inpatient setting may have a lower <u>copay</u> . <u>Preauthorization</u> required for certain services for <u>out-of-network</u> or there is no coverage.
<b>If you are pregnant</b>	Office visits	No Charge	\$190 <u>copay</u> / visit	<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	No Charge	One <u>copay</u> for all covered services related to childbirth/delivery, including the newborn, unless discharged after mother. <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>Preauthorization</u> required for <u>out-of-network</u> inpatient stays beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery or there is no coverage.
	Childbirth/delivery facility services	\$1,050 - \$2,750 <u>copay</u> / stay	\$7,000 <u>copay</u> / stay	

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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	\$70 <u>copay</u> / visit	\$210 <u>copay</u> / visit	Limited to 120 visits per person per <u>plan</u> year. <u>Preauthorization</u> required for certain services for <u>out-of-network</u> or there is no coverage.
	<u>Rehabilitation services</u>	\$15 - \$165 <u>copay</u> / visit	Up to \$300 <u>copay</u> / visit	Limits per person per <u>plan</u> year: Occupational, physical and speech therapy: 60 visits each.
	<u>Habilitation services</u>	\$15 - \$165 <u>copay</u> / visit	Up to \$300 <u>copay</u> / visit	Visits limits for physical, occupational and speech therapy do not apply for the treatment of mental illness or substance-related & addictive disorders, including autism. Limits are a combination of <u>network providers</u> and <u>out-of-network providers</u> per person per <u>plan</u> year. <u>Copays</u> are listed as a range. Providers 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>	\$2,000 <u>copay</u> / stay	\$6,000 <u>copay</u> / stay	Limited to 120 days per person per <u>plan</u> year. <u>Preauthorization</u> required for certain services for <u>out-of-network</u> or there is no coverage.
	<u>Durable medical equipment</u>	\$0 - \$1,000 <u>copay</u> / equipment based on DME tier	Up to \$2,000 <u>copay</u> / equipment based on DME tier	For <u>durable medical equipment (DME)</u> tiers and limitations, visit <a href="http://Join.Surest.com">Join.Surest.com</a> . <u>Preauthorization</u> required for certain DME for <u>out-of-network</u> or there is no coverage.
	<u>Hospice services</u>	Home: \$70 <u>copay</u> / visit Inpatient: \$2,750 <u>copay</u> / stay	Home: \$210 <u>copay</u> / visit Inpatient: \$7,000 <u>copay</u> / stay	<u>Preauthorization</u> required for <u>out-of-network</u> before admission for an Inpatient Stay in a hospice facility or there is no coverage.
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	\$215 <u>copay</u> / visit	Limited to 1 exam every year.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

## 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.)

- |                     |  |  |
|---------------------|--|--|
| • Bariatric surgery | • Infertility treatment                              | • Private-duty nursing   |
| • Cosmetic surgery  | • Long-term care                                     | • Routine foot care (except as covered for certain conditions) |
| • Dental care       | • Non-emergency care when traveling outside the U.S. | • Weight loss programs   |

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

- |   |  |   |
|---|--|---|
| • Acupuncture - 60 visits per plan year       | • Hearing aids - \$5,000 per every 36 months | • Routine eye care (Adult) - 1 exam per plan year |
| • Chiropractic care - 60 visits per plan year |  |   |

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://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 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: the Member Service number listed on the back of your ID card or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.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 1-866-683-6440.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-683-6440.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-683-6440.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-866-683-6440 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-683-6440.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-683-6440.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-683-6440.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-683-6440.

*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)

■ <u>The plan's overall deductible</u>	\$0
■ <u>Specialist copayment</u>	\$30 - \$125
■ <u>Hospital (facility) copayment</u>	\$200 - \$3,500
■ <u>Other coinsurance</u>	\$0

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$12,700</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
<u>Deductibles</u>	<b>\$0</b>
<u>Copayments</u>	<b>\$1100</b>
<u>Coinsurance</u>	<b>\$0</b>
<i>What isn't covered</i>	
Limits or exclusions	<b>\$60</b>
<b>The total Peg would pay is</b>	<b>\$1160</b>

### Managing Joe's Type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$0
■ <u>Specialist copayment</u>	\$30 - \$125
■ <u>Hospital (facility) copayment</u>	\$200 - \$3,500
■ <u>Other coinsurance</u>	\$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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
<u>Deductibles</u>	<b>\$0</b>
<u>Copayments</u>	<b>\$600</b>
<u>Coinsurance</u>	<b>\$0</b>
<i>What isn't covered</i>	
Limits or exclusions	<b>\$0</b>
<b>The total Joe would pay is</b>	<b>\$600</b>

### Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$0
■ <u>Specialist copayment</u>	\$30 - \$125
■ <u>Hospital (facility) copayment</u>	\$200 - \$3,500
■ <u>Other coinsurance</u>	\$0

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
<u>Deductibles</u>	<b>\$0</b>
<u>Copayments</u>	<b>\$1600</b>
<u>Coinsurance</u>	<b>\$0</b>
<i>What isn't covered</i>	
Limits or exclusions	<b>\$0</b>
<b>The total Mia would pay is</b>	<b>\$1600</b>

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