



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, [Benefits.Surest.com](#) website or call 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 <https://healthcare.gov/sbc-glossary/> or call 1-866-683-6440 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://healthcare.gov/coverage/preventive-care-benefits/">https://healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> : \$4,000 individual / \$8,000 family  For <a href="#">out-of-network providers</a> : \$8,000 individual / \$16,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.  If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="#">Join.Surest.com</a> or call 1-866-683-6440 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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 <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$10 - \$65 <a href="#">copayment</a> /visit	\$195 <a href="#">copayment</a> /visit	<p>Certain procedures performed in the office may have a higher office visit <a href="#">copayment</a>.</p> <p><a href="#">Copayments</a> are listed as a range. <a href="#">Providers</a> are assigned <a href="#">copayments</a> within the range based on treatment outcomes and cost information that identifies <a href="#">network providers</a> that provide cost-efficient care.</p> <p>Virtual visits (Primary and Urgent) - No charge per visit by a Designated Virtual <a href="#">Network Providers</a>.</p> <p>Virtual visits (Specialty) - \$10 - \$40 <a href="#">copayment</a> per visit by a Designated Virtual <a href="#">Network Providers</a>.</p> <p>*Cost share applies to any other Telehealth service based on <a href="#">provider</a> type. If you receive services in addition to office visit, additional <a href="#">copayments</a> may apply.</p>
	<a href="#">Specialist</a> visit	\$10 - \$65 <a href="#">copayment</a> /visit	\$195 <a href="#">copayment</a> /visit	
	<a href="#">Preventive care/screening/immunization</a>	No charge	\$100 <a href="#">copayment</a> /visit	
If you have a test	<b>Routine <a href="#">diagnostic test</a></b> (e.g., x-ray, blood work)	<b>Routine <a href="#">diagnostic test</a>:</b> No charge	<b>Routine <a href="#">diagnostic test</a>:</b> No charge	<p><a href="#">Copayments</a> are listed as a range. <a href="#">Providers</a> are assigned <a href="#">copayments</a> within the range based on treatment outcomes and cost information that identifies <a href="#">network providers</a> that provide cost-efficient care.</p> <p><a href="#">Prior authorization</a> is required for certain Non-routine <a href="#">diagnostic tests</a> or there may be no coverage.</p>
	<b>Non-routine <a href="#">diagnostic test</a></b> (e.g., sleep study, genetic testing)	<b>Non-routine <a href="#">diagnostic test</a>:</b> \$20 - \$600 <a href="#">copayment</a> /visit	<b>Non-routine <a href="#">diagnostic test</a>:</b> Up to \$1,800 <a href="#">copayment</a> /visit	
	Imaging (CT/PET scans, MRIs)	\$75 - \$500 <a href="#">copayment</a> /visit	\$1,500 <a href="#">copayment</a> /visit	<p><a href="#">Copayments</a> are listed as a range. <a href="#">Providers</a> are assigned <a href="#">copayments</a> within the range based on treatment outcomes and cost information that identifies <a href="#">network providers</a> that provide cost-efficient care.</p> <p><a href="#">Prior authorization</a> 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](#). After you enroll visit the Surest mobile app or [Benefits.Surest.com](#) website.

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><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="http://www.optumrx.com">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>.</p>	<b>Tier 1 drugs</b>	<b>Retail Pharmacy 31-Day Supply</b> \$15 <a href="#">copayment</a>  <b>Home Delivery</b> \$35 <a href="#">copayment</a>	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 <a href="#">copayments</a> for specific drugs, visit <a href="http://www.optumrx.com">www.optumrx.com</a> website.</p> <p><a href="#">Prior authorization</a> is required for certain drugs or there may be no coverage.</p>
	<b>Tier 2 drugs</b>	<b>Retail Pharmacy 31-Day Supply</b> \$40 <a href="#">copayment</a>  <b>Home Delivery</b> \$100 <a href="#">copayment</a>	Not covered	
	<b>Tier 3 drugs</b>	<b>Retail Pharmacy 31-Day Supply</b> \$60 <a href="#">copayment</a>  <b>Home Delivery</b> \$150 <a href="#">copayment</a>	Not covered	
	<a href="#">Specialty drugs</a>	<b>30-Day Supply</b> \$200 <a href="#">copayment</a>	Not covered	

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)	\$20 - \$2,500 <a href="#">copayment</a> /visit	Up to \$7,000 <a href="#">copayment</a> /visit	<p><a href="#">Copayments</a> are listed as a range. <a href="#">Providers</a> are assigned copayments within the range based on treatment outcomes and cost information that identifies <a href="#">network providers</a> that provide cost-efficient care.</p> <p><a href="#">Prior authorization</a> is required for certain outpatient surgery or there may be no coverage.</p>
	Physician/surgeon fees	No charge	No charge	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$325 <a href="#">copayment</a> /visit	\$325 <a href="#">copayment</a> /visit	<p><a href="#">Copayment</a> is waived if admitted within 24 hours. Out-of-network <a href="#">emergency room care</a> visit <a href="#">copayment</a> applies to the in-network <a href="#">out-of-pocket limit</a>.</p> <p><a href="#">Prior authorization</a> is required for non-<a href="#">emergency medical transportation</a> or there may be no coverage. Out-of-network <a href="#">emergency medical transportation copayment</a> applies to the in-network <a href="#">out-of-pocket limit</a>.</p>
	<a href="#">Emergency medical transportation</a>	\$160 <a href="#">copayment</a> /transport	\$160 <a href="#">copayment</a> /transport	
	<a href="#">Urgent care</a>	\$30 <a href="#">copayment</a> /visit	\$90 <a href="#">copayment</a> /visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 - \$2,500 <a href="#">copayment</a> /stay	Up to \$7,000 <a href="#">copayment</a> /stay	<p><a href="#">Copayments</a> are listed as a range. <a href="#">Providers</a> are assigned copayments within the range based on treatment outcomes and cost information that identifies <a href="#">network providers</a> that provide cost-efficient care.</p> <p><a href="#">Prior authorization</a> is required for non-emergency facility admissions and inpatient surgery or there may be no coverage.</p>
	Physician/surgeon fees	No charge	No charge	

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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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	<b>Home/Office:</b> \$10 <a href="#">copayment</a> /visit <b>Outpatient Facility:</b> \$70 <a href="#">copayment</a> /visit	<b>Home/Office:</b> \$100 <a href="#">copayment</a> /visit <b>Outpatient Facility:</b> \$210 <a href="#">copayment</a> /visit	Certain procedures/services in the outpatient setting may have a lower <a href="#">copayment</a> . <a href="#">Prior authorization</a> is required for certain outpatient services or there may be no coverage.
	Inpatient services	\$1,600 <a href="#">copayment</a> /stay	\$4,800 <a href="#">copayment</a> /stay	Certain procedures/services in the inpatient setting may have a lower <a href="#">copayment</a> . <a href="#">Prior authorization</a> is required for certain inpatient services or there may be no coverage.
<b>If you are pregnant</b>	Office visits	No charge	\$100 <a href="#">copayment</a> /visit	<a href="#">Cost sharing</a> does not apply to <a href="#">preventive services</a> with <a href="#">network providers</a> . Depending on the type of service, a <a href="#">copayment</a> may apply.
	Childbirth/delivery professional services	No charge	No charge	One <a href="#">copayment</a> for all covered services related to childbirth/delivery, including the newborn, unless discharged after mother.
	Childbirth/delivery facility services	\$625 - \$1,375 <a href="#">copayment</a> /stay	\$4,125 <a href="#">copayment</a> /stay	<a href="#">Copayments</a> are listed as a range. <a href="#">Providers</a> are assigned <a href="#">copayments</a> within the range based on treatment outcomes and cost information that identifies <a href="#">network providers</a> that provide cost-efficient care. <a href="#">Prior authorization</a> 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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$30 <a href="#">copayment</a> /visit	\$90 <a href="#">copayment</a> /visit	60 visit limit - combination of <a href="#">network providers</a> and <a href="#">out-of-network providers</a> per person per <a href="#">plan</a> year. <a href="#">Prior authorization</a> is required for certain <a href="#">home health care</a> services or there may be no coverage.
	<a href="#">Rehabilitation services</a>	\$10 - \$60 <a href="#">copayment</a> /visit	Up to \$180 <a href="#">copayment</a> /visit	30 visit limit for occupational therapy 30 visit limit for physical therapy 30 visit limit for speech therapy Visit limits are a combination of <a href="#">network providers</a> and <a href="#">out-of-network providers</a> per person per <a href="#">plan</a> year.
	<a href="#">Habilitation services</a>	\$10 - \$60 <a href="#">copayment</a> /visit	Up to \$180 <a href="#">copayment</a> /visit	<a href="#">Copayments</a> are listed as a range. <a href="#">Providers</a> are assigned <a href="#">copayments</a> within the range based on treatment outcomes and cost information that identifies <a href="#">network providers</a> that provide cost-efficient care.
	<a href="#">Skilled nursing care</a>	\$1,200 <a href="#">copayment</a> /stay	\$3,600 <a href="#">copayment</a> /stay	120 day limit per person per <a href="#">plan</a> year. <a href="#">Prior authorization</a> is required or there may be no coverage.
	<a href="#">Durable medical equipment</a>	\$0 - \$500 <a href="#">copayment</a> /equipment based on <a href="#">DME</a> tier	Up to \$1,000 <a href="#">copayment</a> /equipment based on <a href="#">DME</a> tier	For <a href="#">durable medical equipment (DME)</a> tiers and limitations, visit <a href="#">Join.Surest.com</a> , the Surest mobile app or <a href="#">Benefits.Surest.com</a> website. <a href="#">Prior authorization</a> is required for certain <a href="#">DME</a> or there may be no coverage.
	<a href="#">Hospice services</a>	<b>Home:</b> \$30 <a href="#">copayment</a> /visit <b>Inpatient:</b> \$1,600 <a href="#">copayment</a> /stay	<b>Home:</b> \$90 <a href="#">copayment</a> /visit <b>Inpatient:</b> \$4,800 <a href="#">copayment</a> /stay	None
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	\$195 <a href="#">copayment</a> /visit	One exam per person per plan year
	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](#). After you enroll visit the Surest mobile app or [Benefits.Surest.com](#) website.

## 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](#).)

- Cosmetic surgery
- Hearing aids (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Dental care (Adult)
- Long term care
- Weight loss programs

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

- Acupuncture (No visit limit)
- Infertility treatment (limitations apply)
- Routine eye care (Adult) (limited to one exam per person per [plan](#) year.)
- Bariatric surgery
- Private duty nursing
- Routine foot care (for certain conditions)
- Chiropractic care (No visit limit)

**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](http://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](http://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](http://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.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



## 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)	Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)
<ul style="list-style-type: none"> <li>■ The <a href="#">plan's</a> overall <a href="#">deductible</a> \$0</li> <li>■ <a href="#">Specialist copayment</a> \$0</li> <li>■ Hospital (facility) <a href="#">copayment</a> \$1,375</li> <li>■ Other <a href="#">copayments</a> \$300</li> </ul>	<ul style="list-style-type: none"> <li>■ The <a href="#">plan's</a> overall <a href="#">deductible</a> \$0</li> <li>■ <a href="#">Specialist copayment</a> \$10</li> <li>■ Hospital (facility) <a href="#">copayment</a> \$0</li> <li>■ Other <a href="#">copayments</a> \$1,500</li> </ul>	<ul style="list-style-type: none"> <li>■ The <a href="#">plan's</a> overall <a href="#">deductible</a> \$0</li> <li>■ <a href="#">Specialist copayment</a> \$20</li> <li>■ Hospital (facility) <a href="#">copayment</a> \$325</li> <li>■ Other <a href="#">copayments</a> \$400</li> </ul>
This EXAMPLE event includes services like:	This EXAMPLE event includes services like:	This EXAMPLE event includes services like:
<ul style="list-style-type: none"> <li><a href="#">Specialist</a> office visits (<i>prenatal care</i>)</li> <li>Childbirth/Delivery Professional Services</li> <li>Childbirth/Delivery Facility Services</li> <li><a href="#">Diagnostic tests</a> (<i>ultrasounds and blood work</i>)</li> <li><a href="#">Specialist</a> visit (<i>anesthesia</i>)</li> </ul>	<ul style="list-style-type: none"> <li><a href="#">Primary care physician</a> office visits (<i>including disease education</i>)</li> <li><a href="#">Diagnostic tests</a> (<i>blood work</i>)</li> <li><a href="#">Prescription drugs</a></li> <li><a href="#">Durable medical equipment</a> (<i>glucose meter</i>)</li> </ul>	<ul style="list-style-type: none"> <li><a href="#">Emergency room care</a> (<i>including medical supplies</i>)</li> <li><a href="#">Diagnostic tests</a> (<i>x-ray</i>)</li> <li><a href="#">Durable medical equipment</a> (<i>crutches</i>)</li> <li><a href="#">Rehabilitation services</a> (<i>physical therapy</i>)</li> </ul>
<b>Total Example Cost</b> \$12,700	<b>Total Example Cost</b> \$5,600	<b>Total Example Cost</b> \$2,800
<b>In this example, Peg would pay:</b>	<b>In this example, Joe would pay:</b>	<b>In this example, Mia would pay:</b>
<i>Cost sharing</i>	<i>Cost sharing</i>	<i>Cost sharing</i>
<a href="#">Deductibles</a> \$0	<a href="#">Deductibles</a> \$0	<a href="#">Deductibles</a> \$0
<a href="#">Copayments</a> \$1,675	<a href="#">Copayments</a> \$1,510	<a href="#">Copayments</a> \$745
<a href="#">Coinsurance</a> \$0	<a href="#">Coinsurance</a> \$0	<a href="#">Coinsurance</a> \$0
<i>What isn't covered</i>	<i>What isn't covered</i>	<i>What isn't covered</i>
Limits or exclusions \$20	Limits or exclusions \$0	Limits or exclusions \$0
<b>The total Peg would pay is</b> \$1,695	<b>The total Joe would pay is</b> \$1,510	<b>The total Mia would pay is</b> \$745

The [plan](#) would be responsible for the other costs of these **EXAMPLE** covered services.