



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 deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For network providers : \$6,000 individual / \$12,000 family For out-of-network providers : \$12,000 individual / \$24,000 family	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 , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance billing 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 provider ?	Yes. See Join.Surest.com or call 1-866-683-6440 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*
		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	\$15 - \$100 copayment /visit	\$300 copayment /visit	<p>Certain procedures performed in the office may have a higher office visit copayment.</p> <p>Copayments are listed as a range. Providers are assigned copayments within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care.</p> <p>Virtual visits (Primary and Urgent) - No charge per visit by a Designated Virtual Network Providers.</p> <p>Virtual visits (Specialty) - \$15 - \$60 copayment per visit by a Designated Virtual Network Providers.</p> <p>*Cost share applies to any other Telehealth service based on provider type. If you receive services in addition to office visit, additional copayments may apply.</p>
	Specialist visit	\$15 - \$100 copayment /visit	\$300 copayment /visit	
	Preventive care/screening/immunization	No charge	\$150 copayment /visit	
If you have a test	Routine diagnostic test (e.g., x-ray, blood work)	Routine diagnostic test: No charge	Routine diagnostic test: No charge	<p>Copayments are listed as a range. Providers are assigned copayments within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care.</p> <p>Prior authorization is required for certain Non-routine diagnostic tests or there may be no coverage.</p>
	Non-routine diagnostic test (e.g., sleep study, genetic testing)	Non-routine diagnostic test: \$10 - \$1,100 copayment /visit	Non-routine diagnostic test: Up to \$3,300 copayment /visit	
	Imaging (CT/PET scans, MRIs)	\$100 - \$700 copayment /visit	\$1,875 - \$2,100 copayment /visit	<p>Copayments are listed as a range. Providers are assigned copayments within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care.</p> <p>Prior authorization 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>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.optumrx.com.</p>	Tier 1 drugs	30-Day Supply \$10 copayment 90-Day Supply \$25 copayment	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 copayments for specific drugs, visit www.optumrx.com website.</p> <p>Prior authorization is required for certain drugs or there may be no coverage.</p>
	Tier 2 drugs	30-Day Supply \$60 copayment 90-Day Supply \$150 copayment	Not covered	
	Tier 3 drugs	30-Day Supply \$90 copayment 90-Day Supply \$225 copayment	Not covered	
	Specialty drugs	30-Day Supply Tier 1: \$240 copayment Tier 2: \$270 copayment Tier 3: \$300 copayment	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)	\$40 - \$3,000 copayment /visit	Up to \$9,000 copayment /visit	<p>Copayments are listed as a range. Providers are assigned copayments within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care.</p> <p>Prior authorization 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	Emergency room care	\$500 copayment /visit	\$500 copayment /visit	<p>Copayment is waived if admitted within 24 hours. Out-of-network emergency room care visit copayment applies to the in-network out-of-pocket limit.</p> <p>Prior authorization is required for non-emergency medical transportation or there may be no coverage. Out-of-network emergency medical transportation copayment applies to the in-network out-of-pocket limit.</p>
	Emergency medical transportation	\$250 copayment /transport	\$250 copayment /transport	
	Urgent care	\$50 copayment /visit	\$150 copayment /visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 - \$3,000 copayment /stay	Up to \$9,000 copayment /stay	<p>Copayments are listed as a range. Providers are assigned copayments within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care.</p> <p>Prior authorization 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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Home/Office: \$15 copayment /visit Outpatient Facility: \$125 copayment /visit	Home/Office: \$150 copayment /visit Outpatient Facility: \$375 copayment /visit	Certain procedures/services in the outpatient setting may have a lower copayment . Prior authorization is required for certain outpatient services or there may be no coverage.
	Inpatient services	\$2,000 copayment /stay	\$6,000 copayment /stay	Certain procedures/services in the inpatient setting may have a lower copayment . Prior authorization is required for certain inpatient services or there may be no coverage.
If you are pregnant	Office visits	No charge	\$150 copayment /visit	Cost sharing does not apply to preventive services with network providers . Depending on the type of service, a copayment may apply.
	Childbirth/delivery professional services	No charge	No charge	One copayment for all covered services related to childbirth/delivery, including the newborn, unless discharged after mother.
	Childbirth/delivery facility services	\$900 - \$2,000 copayment /stay	\$6,000 copayment /stay	Copayments are listed as a range. Providers are assigned copayments within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care. Prior authorization 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	Home health care	\$45 copayment /visit	\$135 copayment /visit	60 visit limit - combination of network providers and out-of-network providers per person per plan year. Prior authorization is required for certain home health care services or there may be no coverage.
	Rehabilitation services	\$15 - \$95 copayment /visit	Up to \$285 copayment /visit	40 visit limit for occupational therapy 40 visit limit for physical therapy 30 visit limit for speech therapy Visit limits are a combination of network providers and out-of-network providers per person per plan year.
	Habilitation services	\$15 - \$95 copayment /visit	Up to \$285 copayment /visit	Copayments are listed as a range. Providers are assigned copayments within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care.
	Skilled nursing care	\$1,500 copayment /stay	\$4,500 copayment /stay	120 day limit per person per plan year. Prior authorization is required or there may be no coverage.
	Durable medical equipment	\$0 - \$1,000 copayment /equipment based on DME tier	Up to \$2,000 copayment /equipment based on DME tier	For durable medical equipment (DME) tiers and limitations, visit Join.Surest.com , the Surest mobile app or Benefits.Surest.com website. Prior authorization is required for certain DME or there may be no coverage.
	Hospice services	Home: \$45 copayment /visit Inpatient: \$2,000 copayment /stay	Home: \$135 copayment /visit Inpatient: \$6,000 copayment /stay	None
If your child needs dental or eye care	Children's eye exam	No charge	\$300 copayment /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](#).)

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

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

- Acupuncture (30 visit limit per person per [plan](#) year)
- Hearing aids (limitations apply)
- Routine foot care (for certain conditions)
- Chiropractic care (30 visit limit per person per [plan](#) year)
- Routine eye care (Adult) (limited to one exam per person 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: 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 1-866-683-6440.

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

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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)	
■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0
■ Specialist copayment	\$0	■ Specialist copayment	\$20	■ Specialist copayment	\$30
■ Hospital (facility) copayment	\$2,000	■ Hospital (facility) copayment	\$0	■ Hospital (facility) copayment	\$500
■ Other copayments	\$2,000	■ Other copayments	\$1,800	■ Other copayments	\$400
This EXAMPLE event includes services like:		This EXAMPLE event includes services like:		This EXAMPLE event includes services like:	
Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		Emergency room care (<i>including medical supplies</i>) Diagnostic tests (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost sharing</i>		<i>Cost sharing</i>		<i>Cost sharing</i>	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$2,200	Copayments	\$1,820	Copayments	\$930
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$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
The total Peg would pay is	\$2,220	The total Joe would pay is	\$1,820	The total Mia would pay is	\$930

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