

 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 Benefits.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> ?	Medical / Pharmacy: For network providers: \$0 Pharmacy: For out-of-network providers: \$225 individual / \$450 two-person / \$675 family	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> : Medical: \$6,000 individual / \$12,000 family Pharmacy: \$4,150 individual / \$8,300 family For <u>out-of-network providers</u> : Medical: \$12,000 individual / \$36,000 family Pharmacy: 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 Benefits.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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$40 - \$150 <u>copay</u> /visit	\$220 <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>Specialist</u> visit	\$40 - \$150 <u>copay</u> /visit	\$220 <u>copay</u> /visit	If you receive services in addition to office visit, additional <u>copays</u> may apply, e.g., surgery.
	<u>Preventive care/screening/immunization</u>	No Charge	\$220 <u>copay</u> /visit	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Routine <u>diagnostic test</u> : No Charge Non-routine <u>diagnostic test</u> : \$35 - \$1,850 <u>copay</u> /visit	Routine <u>diagnostic test</u> : No Charge Non-routine <u>diagnostic test</u> : Up to \$3,150 <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>Prior authorization</u> is required <u>out-of-network</u> for certain services or there is no coverage.
	Imaging (CT/PET scans, MRIs)	\$150 - \$2,400 <u>copay</u> /visit	Up to \$5,850 <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.

*For more information about limitations and exceptions, see the plan or policy document at [Benefits.Surest.com](https://www.benefits.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 drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at Caremark.com .	Generic Drugs (Tier 1)	Retail Up to 31-Day Supply \$20 <u>copay</u> Retail & Mail Order Up to 90-Day Supply \$50 <u>copay</u>	Retail Up to 31-Day Supply 50% <u>coinsurance</u> After <u>deductible</u> Retail & Mail Order Up to 90-Day Supply Not Covered	Certain preventive medications (including certain contraceptives) are covered at No charge. To learn more about drug tiers and about <u>copays</u> for specific drugs, visit Caremark.com website. <u>Prior authorization</u> is required for certain drugs or there may be no coverage.
	Preferred brand drugs (Tier 2)	Retail Up to 31-Day Supply 50% <u>coinsurance</u> \$30 Min, \$150 Max Retail & Mail Order Up to 90-Day Supply 50% <u>coinsurance</u> \$75 Min, \$375 Max	Retail Up to 31-Day Supply 50% <u>coinsurance</u> After <u>deductible</u> Retail & Mail Order Up to 90-Day Supply Not Covered	
	Non-preferred brand drugs (Tier 3)	Retail Up to 31-Day Supply 50% <u>coinsurance</u> \$30 Min, \$150 Max Retail & Mail Order Up to 90-Day Supply 50% <u>coinsurance</u> \$75 Min, \$375 Max	Retail Up to 31-Day Supply 50% <u>coinsurance</u> After <u>deductible</u> Retail & Mail Order Up to 90-Day Supply 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)	\$70 - \$4,500 <u>copay</u> /visit	Up to \$11,000 <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>Prior authorization</u> is required <u>out-of-network</u> for certain services or there is no coverage.
	Physician/surgeon fees	No Charge	No Charge	
If you need immediate medical attention	<u>Emergency room care</u>	\$550 <u>copay</u> /visit	\$550 <u>copay</u> /visit	<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>. <u>Prior authorization</u> is required for non-emergency medical transportation or there is no coverage. <u>Out-of-network emergency medical transportation copay</u> applies to the <u>in-network out-of-pocket limit</u>.
	<u>Emergency medical transportation</u>	\$330 <u>copay</u> /transport	\$330 <u>copay</u> /transport	
	<u>Urgent care</u>	\$125 <u>copay</u> /visit	\$375 <u>copay</u> /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$600 - \$4,500 <u>copay</u> /stay	Up to \$11,000 <u>copay</u> /stay	<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>Prior authorization</u> is required <u>out-of-network</u> for non-emergency facility admissions and inpatient surgery or there is no coverage.
	Physician/surgeon fees	No Charge	No Charge	

*For more information about limitations and exceptions, see the plan or policy document at [Benefits.Surest.com](https://www.surest.com/benefits).

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	Office Visit: \$40 <u>copay</u> /visit Outpatient Facility: \$180 <u>copay</u> /visit	Office Visit: \$80 <u>copay</u> /visit Outpatient Facility: \$540 <u>copay</u> /visit	Certain services performed in an office setting may have a different <u>copay</u> that is not higher than the outpatient facility <u>copay</u> . The type of service will determine the <u>copay</u> amount you owe, not the setting. <u>Prior authorization</u> is required <u>out-of-network</u> for certain services or there is no coverage.
	Inpatient services	\$2,700 <u>copay</u> /stay	\$8,100 <u>copay</u> /stay	<u>Prior authorization</u> is required <u>out-of-network</u> for certain services or there is no coverage.
If you are pregnant	Office visits	No Charge	\$220 <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. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound). <u>Prior authorization</u> is required <u>out-of-network</u> for 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	\$1,500 - \$3,000 <u>copay</u> /stay	\$9,000 <u>copay</u> /stay	

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>	\$80 <u>copay</u> /visit	\$240 <u>copay</u> /visit	100 visit limit per person per <u>plan</u> year. Visit limits are combination of <u>network providers</u> and <u>out-of-network providers</u> per person per <u>plan</u> year. <u>Prior authorization</u> is required <u>out-of-network</u> for certain services or there is no coverage.
	<u>Rehabilitation services</u>	\$20 - \$200 <u>copay</u> /visit	Up to \$330 <u>copay</u> /visit	100 visit limit for occupational therapy 100 visit limit for physical therapy 100 visit limit for speech therapy Visit limits are a combination of <u>network providers</u> and <u>out-of-network providers</u> per person per <u>plan</u> year.
	<u>Habilitation services</u>	\$20 - \$200 <u>copay</u> /visit	Up to \$330 <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>Skilled nursing care</u>	\$2,700 <u>copay</u> /stay	\$8,100 <u>copay</u> /stay	100 day limit per person per <u>plan</u> year. <u>Prior authorization</u> is required <u>out-of-network</u> or there is no coverage.
	<u>Durable medical equipment</u>	\$0 - \$1,000 <u>copay</u> /item	Up to \$2,000 <u>copay</u> /item	For <u>durable medical equipment (DME)</u> limitations, visit Benefits.Surest.com . <u>Prior authorization</u> is required <u>out-of-network</u> for certain <u>DME</u> or there is no coverage.
	<u>Hospice services</u>	Home: \$80 <u>copay</u> /visit Inpatient: \$3,500 <u>copay</u> /stay	Home: \$240 <u>copay</u> /visit Inpatient: \$10,500 <u>copay</u> /stay	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Children's eye exam is not covered.
	Children's glasses	Not Covered	Not Covered	Child glasses are not covered.
	Children's dental check-up	Not Covered	Not Covered	Child dental check-up is not covered.

*For more information about limitations and exceptions, see the plan or policy document at [Benefits.Surest.com](https://www.benefits.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.)

- Cosmetic surgery
- Dental care (Adult)
- Long term care
- Non-emergency care when traveling outside the U.S.
- 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 (30 visit limit per person per plan year)
- Bariatric surgery
- Chiropractic care (30 visit limit per person per plan year)
- Hearing aids (\$5,000 per every 36 months.)
- Infertility treatment (Limitations apply)
- Private duty nursing
- 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 [1-866-683-6440].

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 (Deitsch): Fer Hilf griegie in Deitsch, ruf [1-866-683-6440] uff.

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

Samoa (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)		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 <u>plan's</u> overall <u>deductible</u>	\$0	■ The <u>plan's</u> overall <u>deductible</u>	\$0	■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$40 - \$150	■ <u>Specialist copayment</u>	\$40 - \$150	■ <u>Specialist copayment</u>	\$40 - \$150
■ Hospital (facility) <u>copayment</u>	\$600 - \$4,500	■ Hospital (facility) <u>copayment</u>	\$600 - \$4,500	■ Hospital (facility) <u>copayment</u>	\$600 - \$4,500
■ Other <u>coinsurance</u>	\$0	■ Other <u>coinsurance</u>	\$0	■ Other <u>coinsurance</u>	\$0
This EXAMPLE event includes services like: <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose meter</i>)		This EXAMPLE event includes services like: <u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic tests</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<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:	
Cost sharing		Cost sharing		Cost sharing	
<u>Deductibles</u>	\$0	<u>Deductibles</u>	\$0	<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,500	<u>Copayments</u>	\$1,600	<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$1,560	The total Joe would pay is	\$1,600	The total Mia would pay is	\$1,100

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