**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 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. Preventive Care. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copay 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 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: $9,000 individual / $18,000 family<br>For out-of-network providers: Not covered | The out-of-pocket limit is the most you could pay in a year for covered services.<br>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 | $50 - $160 copay/visit | Not covered | Certain procedures performed in the office may have a higher office visit copay.<br>Copays are listed as a range. Providers are assigned copays within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care.<br><br>*Cost share applies to any other Telehealth service based on provider type. If you receive services in addition to office visit, additional copays may apply. |
| | Specialist visit | $50 - $160 copay/visit | Not covered | |
| | Preventive care/screening/ immunization | No charge | Not covered | You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | **Routine** diagnostic test (e.g., x-ray, blood work)<br>**Non-routine** diagnostic test (e.g., sleep study, genetic testing) | **Routine** diagnostic test**:** No charge<br>**Non-routine** diagnostic test**:** $45 - $2,100 copay/visit | **Routine** diagnostic test**:** No charge<br>**Non-routine** diagnostic test**:** Not covered | Copays are listed as a range. Providers are assigned copays within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care.<br>Prior authorization is required for certain Non-routine diagnostic tests or there may be no coverage. |
| | Imaging (CT/PET scans, MRIs) | $200 - $2,900 copay/visit | Not covered | Copays are listed as a range. Providers are assigned copays within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care.<br>Prior authorization is required for certain imaging tests or there may be no coverage. |

*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 drugs to treat your illness or condition**<br>More information about prescription drug coverage is available at Optumrx.com. | **Preventive Pharmacy** | **Up to 90 Day Supply**<br>No charge | Not covered | Certain Tier 1 drugs are available with no charge, including prescribed generic contraceptives and tobacco cessation medications.<br>To learn more about drug tiers and about copays for specific drugs, visit Optumrx.com website.<br>Prior authorization is required for certain drugs or there may be no coverage. |
| | **Tier 1 drugs** | **Up to 31 Day Supply**<br>$10 copay<br>**Up to 90 Day Supply**<br>$30 copay | Not covered | |
| | **Tier 2 drugs** | **Up to 31 Day Supply**<br>$90 copay<br>**Up to 90 Day Supply**<br>$270 copay | Not covered | |
| | **Tier 3 drugs** | **Up to 31 Day Supply**<br>$200 copay<br>**Up to 90 Day Supply**<br>$600 copay | Not covered | |
| | **Tier 4 drugs** | **Up to 31 Day Supply**<br>$600 copay<br>**Up to 90 Day Supply**<br>$1,800 copay | Not covered | Specialty drugs are not covered at a 90-day supply.<br>Prior authorization is required for certain specialty drugs 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 have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $80 - $5,500 copay/visit | Not covered | Copays are listed as a range. Providers are assigned copays within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care.<br>Prior authorization is required for certain outpatient surgery or there may be no coverage. |
| | Physician/surgeon fees | No charge | Not covered | |
| **If you need immediate medical attention** | Emergency room care | $1,000 copay/visit | $1,000 copay/visit | Copay is waived if admitted within 24 hours. Out-of-network emergency room care visit copay applies to the in-network out-of-pocket limit. |
| | Emergency medical transportation | $700 copay/transport | $700 copay/transport | Prior authorization is required for non-emergency medical transportation or there may be no coverage. Out-of-network emergency medical transportation copay applies to the in-network out-of-pocket limit. |
| | Urgent care | $110 copay/visit | Not covered | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $500 - $5,500 copay/stay | Not covered | Copays are listed as a range. Providers are assigned copays within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care.<br>Prior authorization is required for non-emergency facility admissions and inpatient surgery or there may be no coverage. |
| | 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**: $50 copay/visit<br>**Outpatient Facility**: $200 copay/visit | **Home/Office**: Not covered<br>**Outpatient Facility** Not covered | Certain procedures/services in the outpatient setting may have a lower copay.<br>Prior authorization is required for certain outpatient services or there may be no coverage. |
| | Inpatient services | $3,000 copay/stay | Not covered | Certain procedures/services in the inpatient setting may have a lower copay.<br>Prior authorization is required for certain inpatient services or there may be no coverage. |
| **If you are pregnant** | Office visits | No charge | Not covered | Cost sharing does not apply to preventive services with network providers.<br>Depending on the type of service, a copay may apply. |
| | Childbirth/delivery professional services | No charge | Not covered | One copay for all covered services related to childbirth/delivery, including the newborn, unless discharged after mother.<br>Copays are listed as a range. Providers are assigned copays within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care.<br>Cost sharing does not apply to certain preventive services.<br>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. |
| | Childbirth/delivery facility services | $2,400 - $4,500 copay/stay | 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 need help recovering or have other special health needs** | Home health care | $90 copay/visit | Not covered | 120 visit limit - combination of network providers and out-of-network providers per person per plan year.<br>Prior authorization is required for certain home health care services or there may be no coverage. |
| | Rehabilitation services | $25 - $210 copay/visit | Not covered | 20 visit limit for occupational therapy<br>20 visit limit for physical therapy<br>20 visit limit for speech therapy<br>Visit limits are a combination of network providers and out-of-network providers per person per plan year.<br>Copays are listed as a range. Providers are assigned copays within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care. |
| | Habilitation services | $25 - $210 copay/visit | Not covered | |
| | Skilled nursing care | $3,500 copay/stay | Not covered | 120 day limit per person per plan year.<br>Prior authorization is required or there may be no coverage. |
| | Durable medical equipment | $0 - $1,000 copay/equipment based on DME tier | Not covered | Prior authorization is required for certain DME or there may be no coverage. |
| | Hospice services | **Home**: $90 copay/visit<br>**Inpatient**: $4,500 copay/stay | **Home**: Not covered<br>**Inpatient**: Not covered | None |
| **If your child needs dental or eye care** | Children's eye exam | No charge | Not covered | 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.

## 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 (Limitations apply
- Long term 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 (20 visit limit per person per plan year)
- Chiropractic care (20 visit limit per person per plan year)
- Hearing aids (limitations apply)
- Private duty nursing
- Routine eye care (Adult) (limited to one exam per person per plan year.)
- 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. 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.

**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, kwiijigo 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 alillis reel kapasal Falawasch au fafaingi tilifon ye [1-866-633-2446].

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'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 | $50 - $160 |
| Hospital (facility) copayment | $500 - $5,500 |
| 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 | |
| Deductibles | $0 |
| Copayments | $2,400 |
| Coinsurance | $0 |
| What isn't covered | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,460** |

### 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 | $50 - $160 |
| Hospital (facility) copayment | $500 - $5,500 |
| 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 | |
| Deductibles | $0 |
| Copayments | $2,000 |
| Coinsurance | $0 |
| What isn't covered | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$2,000** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $50 - $160 |
| Hospital (facility) copayment | $500 - $5,500 |
| 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 | |
| Deductibles | $0 |
| Copayments | $1,900 |
| Coinsurance | $0 |
| What isn't covered | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,900** |

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