



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 : \$7,000 individual / \$14,000 family For out-of-network providers : \$14,000 individual / \$28,000 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	\$20 - \$125 copayment /visit	\$375 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) - \$35 - \$100 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	\$20 - \$125 copayment /visit	\$375 copayment /visit	
	Preventive care/screening/immunization	No charge	\$235 copayment /visit	
If you have a test	Routine diagnostic test (e.g., x-ray, blood work) Non-routine diagnostic test (e.g., sleep study, genetic testing)	Routine diagnostic test: No charge Non-routine diagnostic test: \$40 - \$1,800 copayment /visit	Routine diagnostic test: No charge Non-routine diagnostic test: Up to \$5,400 copayment /visit	None
	Imaging (CT/PET scans, MRIs)	\$200 - \$1,150 copayment /visit	\$3,000 to \$3,450 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.expressscripts.com.</p>	Generic Drugs	30-Day Supply \$20 copayment 90-Day Supply \$50 copayment	Not covered	<p>Certain generic 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.expressscripts.com website.</p> <p>Prior authorization is required for certain drugs or there may be no coverage.</p>
	Preferred Brand Drugs	30-Day Supply \$60 copayment 90-Day Supply \$150 copayment	Not covered	
	Non-Preferred Brand Drugs	30-Day Supply \$120 copayment 90-Day Supply \$300 copayment	Not covered	
	Specialty drugs	90-Day Supply Tier 1: \$50 copayment Tier 2: \$150 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)	\$80 - \$5,500 copayment /visit	Up to \$13,000 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	\$1,000 copayment /visit	\$1,000 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	\$500 copayment /transport	\$500 copayment /transport	
	Urgent care	\$110 copayment /visit	\$330 copayment /visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$400 - \$5,500 copayment /stay	Up to \$13,000 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: \$20 copayment /visit Outpatient Facility: \$200 copayment /visit	Home/Office: \$235 copayment /visit Outpatient Facility: \$600 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	\$4,500 copayment /stay	\$13,000 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	\$235 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	\$2,500 - \$4,500 copayment /stay	\$13,000 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	\$90 copayment /visit	\$270 copayment /visit	120 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	\$35 - \$150 copayment /visit	Up to \$450 copayment /visit	No visit limit for occupational therapy No visit limit for physical therapy No 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	\$35 - \$150 copayment /visit	Up to \$450 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	\$3,500 copayment /stay	\$10,500 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: \$90 copayment /visit Inpatient: \$4,500 copayment /stay	Home: \$270 copayment /visit Inpatient: \$13,000 copayment /stay	None
	If your child needs dental or eye care	Children's eye exam	No charge	\$465 copayment /visit
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
- Dental care (Adult)
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- 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 (12 visit limit per person per [plan](#) year)
- Bariatric surgery
- Chiropractic care (30 visit limit per person per [plan](#) year)
- Hearing aids (limitations apply)
- 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.

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)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) copayment	\$4,500
■ Other copayments	\$500

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	\$5,000
Coinsurance	\$0

What isn't covered

Limits or exclusions \$20

The total Peg would pay is \$5,020

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	\$20
■ Hospital (facility) copayment	\$0
■ Other copayments	\$2,100

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	\$2,120
Coinsurance	\$0

What isn't covered

Limits or exclusions \$0

The total Joe would pay is \$2,120

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$40
■ Hospital (facility) copayment	\$1,000
■ Other copayments	\$800

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	\$1,840
Coinsurance	\$0

What isn't covered

Limits or exclusions \$0

The total Mia would pay is \$1,840

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