**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://www.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://www.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: $5,500 individual / $11,000 family<br>For out-of-network providers: $11,000 individual / $22,000 family | 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 | $25 - $125 copayment/visit | $375 copayment/visit | Certain procedures performed in the office may have a higher office visit copayment.<br>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.<br>Virtual visits - No charge per visit by a Designated Virtual Network Provider.<br>*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. |
| | Specialist visit | $25 - $125 copayment/visit | $375 copayment/visit | |
| | Preventive care/screening/ immunization | No charge | $190 copayment/visit | 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** | Diagnostic test (e.g., x-ray, blood work) | **Routine diagnostic test:** No charge<br>**Non-routine diagnostic test:** $40 - $1,150 copayment/visit | **Routine diagnostic test:** No charge<br>**Non-routine diagnostic test:** Up to $3,450 copayment/visit | None |
| | Imaging (CT/PET scans, MRIs) | $200 - $950 copayment/visit | $2,850 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.<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. 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) | |
| **If you need drugs to treat your illness or condition**<br>More information about prescription drug coverage is available at Optumrx.com. | **Tier 1 drugs** | **30-Day Supply**<br>$10 copayment<br><br>**90-Day Supply**<br>$25 copayment | Not covered | Certain Tier 1 drugs are available with $0 copayments, including prescribed generic contraceptives and tobacco cessation medications.<br>To learn more about drug tiers and about copayments for specific drugs, visit Optumrx.com.<br>Prior authorization is required for certain drugs or there may be no coverage. |
| | **Tier 2 drugs** | **30-Day Supply**<br>$90 copayment<br><br>**90-Day Supply**<br>$225 copayment | Not covered | |
| | **Tier 3 drugs** | **30-Day Supply**<br>$120 copayment<br><br>**90-Day Supply**<br>$300 copayment | Not covered | |
| | Specialty drugs | **30-Day Supply**<br>Tier 1: $330 copayment<br>Tier 2: $370 copayment<br>Tier 3: $400 copayment | 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) | $50 - $3,500 copayment/visit | Up to $10,000 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.<br>Prior authorization is required for certain outpatient surgery or there may be no coverage. |
| | Physician/surgeon fees | No charge | No charge | |
| **If you need immediate medical attention** | Emergency room care | $700 copayment/visit | $700 copayment/visit | 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. |
| | Emergency medical transportation | $350 copayment/transport | $350 copayment/transport | 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. |
| | Urgent care | $70 copayment/visit | $210 copayment/visit | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $400 - $3,500 copayment/stay | Up to $10,000 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.<br>Prior authorization is required for non-emergency facility admissions and inpatient surgery or there may be no coverage. |
| | Physician/surgeon fees | No charge | No charge | |

*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) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | **Home/Office**: $25 copayment/visit<br>**Outpatient Facility**: $140 copayment/visit | **Home/Office**: $190 copayment/visit<br>**Outpatient Facility**: $420 copayment/visit | Certain procedures/services in the outpatient setting may have a lower copayment.<br>Prior authorization is required for certain outpatient services or there may be no coverage. |
| | Inpatient services | $2,750 copayment/stay | $8,250 copayment/stay | Certain procedures/services in the inpatient setting may have a lower copayment.<br>Prior authorization is required for certain inpatient services or there may be no coverage. |
| **If you are pregnant** | Office visits | No charge | $190 copayment/visit | Cost sharing does not apply to preventive services with network providers.<br>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.<br>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.<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 | $1,300 - $2,350 copayment/stay | $7,050 copayment/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** | Home health care | $60 copayment/visit | $180 copayment/visit | 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 | $15 - $115 copayment/visit | Up to $345 copayment/visit | 60 visit limit for occupational therapy<br>60 visit limit for physical therapy<br>60 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>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. |
| | Habilitation services | $15 - $115 copayment/visit | Up to $345 copayment/visit | |
| | Skilled nursing care | $2,000 copayment/stay | $6,000 copayment/stay | 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 copayment/ equipment based on DME tier | $20 - $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.<br>Prior authorization is required for certain DME or there may be no coverage. |
| | Hospice services | **Home**: $60 copayment/visit<br>**Inpatient**: $2,750 copayment/stay | **Home**: $180 copayment/visit<br>**Inpatient**: $8,250 copayment/stay | Prior authorization is required for certain hospice services or there may be no coverage. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | $375 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.)**

- Children's glasses
- Children's dental check-up
- Cosmetic surgery
- Dental care (Adult)
- 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 (60 visit limit per person per plan year)
- Bariatric surgery
- Chiropractic care (60 visit limit per person per plan year)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- 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. The contact information for those agencies is: the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.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 www.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 www.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.*

## 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 | $2,350 |
| ■ Other copayments | $400 |

**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 | $2,750 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Peg would pay is** | **$2,770** |

### 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 | $30 |
| ■ Hospital (facility) copayment | $0 |
| ■ Other copayments | $2,000 |

**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 | $2,030 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$2,030** |

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

| | |
|---|---|
| ■ The plan's overall deductible | $0 |
| ■ Specialist copayment | $50 |
| ■ Hospital (facility) copayment | $700 |
| ■ Other copayments | $600 |

**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 | $1,350 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,350** |

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