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 or by calling 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 www.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. This plan does not have a deductible.	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 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: $5,000 Individual / $10,000 Family For out-of-network providers: $10,000 Individual / $20,000 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, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	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
		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 - $105 copay / visit	$215 copay / visit	Certain procedures performed in the office may have a higher office visit copay. 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. Office Visit 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	$20 - $105 copay / visit	$215 copay / visit	
	Preventive care/ screening/ immunization	No Charge	$160 copay / visit	You may have to pay for services that aren't 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 (x-ray, blood work)	Routine diagnostic test: No Charge Non-routine diagnostic test: $20 - $1,050 copay / visit	Routine diagnostic test: No Charge Non-routine diagnostic test: Up to $2,400 copay / visit	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. Preauthorization required for certain services for out-of-network or benefit reduces to 50% of allowed amount.
	Imaging (CT/PET scans, MRIs)	$125 - $850 copay / visit	Up to $1,650 copay / visit	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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 prescription drug coverage is available at Optumrx.com	Tier 1 (Generic drugs)	30-Day Supply $10 copay 90-Day Supply $25 copay	Not Covered	Certain Tier 1 drugs are available with $0 copays, including prescribed generic contraceptives and tobacco cessation medications. To learn more about drug tiers and about copays for specific drugs, visit Optumrx.com. Preauthorization is required for certain drugs or may result in a higher cost.
	Tier 2 (Preferred brand drugs)	30-Day Supply $60 copay 90-Day Supply $150 copay	Not Covered	
	Tier 3 (Non-preferred brand drugs)	30-Day Supply $90 copay 90-Day Supply $225 copay	Not Covered	
	Specialty drugs	30-Day Supply Tier 1: $10 copay Tier 2: $150 copay Tier 3: $300 copay	Not Covered	Specialty drugs are not covered at a 90-day supply. Preauthorization is required for certain specialty drugs or may result in a higher cost.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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)	$35 - $3000 copay / visit	Up to $9000 copay / visit	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. Preauthorization required for certain services for out-of-network or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	No Charge	No Charge	
If you need immediate medical attention	Emergency room care	$600 copay / visit	$600 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	$350 copay / transport	$350 copay / transport	Out-of-network emergency medical transportation copay applies to the in-network out-of-pocket limit.
	Urgent care	$60 copay / visit	$180 copay / visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 - $3,000 copay / stay	Up to $9,000 copay / stay	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. Preauthorization required for certain services for out-of-network or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	No Charge	No Charge	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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 copay / visit Outpatient Facility: $130 copay / visit	Home/Office: $160 copay / visit Outpatient Facility: $390 copay / visit	Certain procedures/services in the outpatient setting may have a lower copay. Preauthorization required for certain services for out-of-network or benefit reduces to 50% of allowed amount.
	Inpatient services	$2,000 copay / stay	$6,000 copay / stay	Certain procedures/services in the inpatient setting may have a lower copay. Preauthorization required for certain services for out-of-network or benefit reduces to 50% of allowed amount.
If you are pregnant	Office visits	No Charge	$160 copay / visit	Cost sharing does not apply to preventive services with network providers. Depending on the type of service, a copay may apply.
	Childbirth/delivery professional services	No Charge	No Charge	One copay for all covered services related to childbirth/delivery, including the newborn, unless discharged after mother. 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. Preauthorization required for out-of-network inpatient stays beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery or benefit reduces to 50% of allowed amount.
	Childbirth/delivery facility services	$900 - $2,000 copay / stay	$6,000 copay / stay	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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 copay / visit	$180 copay / visit	Limited to 120 visits per person per plan year. Preauthorization required for certain services for out-of-network or benefit reduces to 50% of allowed amount.
	Rehabilitation services	$10 - $130 copay / visit	Up to $240 copay / visit	Limits per person per plan year: Occupational, physical and speech therapy: 60 visits each. Visits limits for physical, occupational and speech therapy do not apply for the treatment of mental illness or substance-related & addictive disorders, including autism. Limits are a combination of network providers and out-of-network providers per person per plan year. 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	$10 - $130 copay / visit	Up to $240 copay / visit	
	Skilled nursing care	$1,500 copay / stay	$4,500 copay / stay	Limited to 120 days per person per plan year. Preauthorization required for certain services for out-of-network or benefit reduces to 50% of allowed amount.
	Durable medical equipment	$0 - $1,000 copay / equipment based on DME tier	Up to $2,000 copay / equipment based on DME tier	For durable medical equipment (DME) tiers and limitations, visit Join.Surest.com. Preauthorization required for certain DME for out-of-network or benefit reduces to 50% of allowed amount.
	Hospice services	Home: $60 copay / visit Inpatient: $2,000 copay / stay	Home: $180 copay / visit Inpatient: $6,000 copay / stay	Preauthorization required for out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount.
If your child needs dental or eye care	Children's eye exam	No Charge	$215 copay / visit	Limited to 1 exam every year.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Bariatric surgery	• Infertility treatment	• Private-duty nursing
• Cosmetic surgery	• Long-term care	• Routine foot care (except as covered for certain conditions)
• Dental 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 - 60 visits per plan year	• Hearing aids	• Routine eye care (Adult) - 1 exam per plan year
• Chiropractic care - 60 visits 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 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 www.dol.gov/ebsa/healthreform or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or the Nevada Division of Insurance at 1-501-371-2640 or 1-800-852-5494 or www.doi.state.nv.us.

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): 如果需要中文的幫助, 請撥打這個號碼 1-866-683-6440.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-683-6440.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-866-683-6440 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-683-6440.
Samoan (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, å'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)

The plan's overall deductible	$0
Specialist copayment	$20 - $105
Hospital (facility) copayment	$200 - $3,000
Other coinsurance	$0

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal 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	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$960**

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 - $105
Hospital (facility) copayment	$200 - $3,000
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	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$500**

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

The plan's overall deductible	$0
Specialist copayment	$20 - $105
Hospital (facility) copayment	$200 - $3,000
Other coinsurance	$0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(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	$1100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1100**

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