

 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
<u>What is the overall deductible?</u>	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
<u>Are there services covered before you meet your deductible?</u>	Yes. This <u>plan</u> does not have a <u>deductible</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 <u>plan</u> 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 www.healthcare.gov/coverage/preventive-care-benefits/ .
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	For <u>network providers</u> : \$6,500 Individual / \$13,000 Family For <u>out-of-network providers</u> : \$13,000 Individual / \$26,000 Family	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.
<u>What is not included in the out-of-pocket limit?</u>	<u>Premiums</u> , <u>balance billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>preauthorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. See Join.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.
<u>Do you need a referral to see a 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
		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 - \$130 <u>copay</u> / visit	\$215 <u>copay</u> / visit	Certain procedures performed in the office may have a higher office visit <u>copay</u> . <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. Office Visit cost share applies to any other Telehealth service based on <u>provider</u> type. If you receive services in addition to office visit, additional <u>copays</u> may apply.
	<u>Specialist</u> visit	\$25 - \$130 <u>copay</u> / visit	\$215 <u>copay</u> / visit	
	<u>Preventive care/ screening/ immunization</u>	No Charge	\$195 <u>copay</u> / visit	You may have to pay for services that aren't <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> : \$25 - \$1,300 <u>copay</u> / visit	Routine <u>diagnostic test</u> : No Charge Non-routine <u>diagnostic test</u> : Up to \$2,700 <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.
	Imaging (CT/PET scans, MRIs)	\$150 - \$1,050 <u>copay</u> / visit	Up to \$1,650 <u>copay</u> / visit	<u>Preauthorization</u> required for certain services for <u>out-of-network</u> or there is no coverage.

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)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at Optumrx.com</p>	<p>Tier 1 (Generic drugs)</p>	<p>30-Day Supply \$20 <u>copay</u></p> <p>90-Day Supply \$50 <u>copay</u></p>	Not Covered	<p>Certain Tier 1 drugs are available with \$0 <u>copays</u>, including prescribed generic contraceptives and tobacco cessation medications.</p> <p>To learn more about drug tiers and about <u>copays</u> for specific drugs, visit Optumrx.com.</p>
		<p>30-Day Supply \$90 <u>copay</u></p> <p>90-Day Supply \$225 <u>copay</u></p>	Not Covered	
	<p>Tier 3 (Non-preferred brand drugs)</p>	<p>30-Day Supply \$150 <u>copay</u></p> <p>90-Day Supply \$375 <u>copay</u></p>	Not Covered	<p><u>Preauthorization</u> is required for certain drugs or may result in a higher cost.</p>
		<p>30-Day Supply Tier 1: \$20 <u>copay</u></p> <p>Tier 2: \$200 <u>copay</u></p> <p>Tier 3: \$500 <u>copay</u></p>	Not Covered	<p><u>Specialty drugs</u> are not covered at a 90-day supply.</p> <p><u>Preauthorization</u> is required for certain <u>specialty drugs</u> or may result in a higher cost.</p>

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)	\$40 - \$3500 <u>copay</u> / visit	Up to \$10000 <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>Preauthorization</u> required for certain services for <u>out-of-network</u> or there is no coverage.
	Physician/surgeon fees	No Charge	No Charge	
If you need immediate medical attention	<u>Emergency room care</u>	\$850 <u>copay</u> / visit	\$850 <u>copay</u> / visit	<u>Copay</u> is waived if admitted within 24 hours. Out-of-network <u>emergency room care</u> visit <u>copay</u> applies to the in-network <u>out-of-pocket limit</u> .
	<u>Emergency medical transportation</u>	\$500 <u>copay</u> / transport	\$500 <u>copay</u> / transport	Out-of-network <u>emergency medical transportation copay</u> applies to the in-network <u>out-of-pocket limit</u> .
	<u>Urgent care</u>	\$80 <u>copay</u> / visit	\$200 <u>copay</u> / visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$350 - \$3,500 <u>copay</u> / stay	Up to \$10,000 <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>Preauthorization</u> required for certain services for <u>out-of-network</u> or there is no coverage.
	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: \$25 <u>copay</u> / visit Outpatient Facility: \$170 <u>copay</u> / visit	Home/Office: \$195 <u>copay</u> / visit Outpatient Facility: \$510 <u>copay</u> / visit	Certain procedures/services in the outpatient setting may have a lower <u>copay</u> . <u>Preauthorization</u> required for certain services for <u>out-of-network</u> or there is no coverage.
	Inpatient services	\$2,750 <u>copay</u> / stay	\$8,250 <u>copay</u> / stay	Certain procedures/services in the inpatient setting may have a lower <u>copay</u> . <u>Preauthorization</u> required for certain services for <u>out-of-network</u> or there is no coverage.
If you are pregnant	Office visits	No Charge	\$195 <u>copay</u> / visit	Cost sharing 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.
	Childbirth/delivery facility services	\$1,300 - \$2,750 <u>copay</u> / stay	\$8,250 <u>copay</u> / stay	<u>Preauthorization</u> required for <u>out-of-network</u> inpatient stays beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery or there is no coverage.

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	<u>Home health care</u>	\$70 <u>copay</u> / visit	\$210 <u>copay</u> / visit	Limited to 120 visits per person per <u>plan</u> year. <u>Preauthorization</u> required for certain services for <u>out-of-network</u> or there is no coverage.
	<u>Rehabilitation services</u>	\$15 - \$165 <u>copay</u> / visit	Up to \$300 <u>copay</u> / visit	Limits per person per <u>plan</u> 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 <u>network providers</u> and <u>out-of-network providers</u> per person per <u>plan</u> year. <u>Copays</u> are listed as a range. Providers 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>Habilitation services</u>	\$15 - \$165 <u>copay</u> / visit	Up to \$300 <u>copay</u> / visit	
	<u>Skilled nursing care</u>	\$2,000 <u>copay</u> / stay	\$6,000 <u>copay</u> / stay	Limited to 120 days per person per <u>plan</u> year. <u>Preauthorization</u> required for certain services for <u>out-of-network</u> or there is no coverage.
	<u>Durable medical equipment</u>	\$0 - \$1,000 <u>copay</u> / equipment based on DME tier	Up to \$2,000 <u>copay</u> / equipment based on DME tier	For <u>durable medical equipment (DME)</u> tiers and limitations, visit Join.Surest.com . <u>Preauthorization</u> required for certain DME for <u>out-of-network</u> or there is no coverage.
	<u>Hospice services</u>	Home: \$70 <u>copay</u> / visit Inpatient: \$2,750 <u>copay</u> / stay	Home: \$210 <u>copay</u> / visit Inpatient: \$8,250 <u>copay</u> / stay	<u>Preauthorization</u> required for <u>out-of-network</u> before admission for an Inpatient Stay in a hospice facility or there is no coverage.
	<u>Children's eye exam</u>	No Charge	\$215 <u>copay</u> / visit	Limited to 1 exam every year.
If your child needs dental or eye care	<u>Children's glasses</u>	Not Covered	Not Covered	No coverage for Children's glasses.
	<u>Children's dental check-up</u>	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.)

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|---------------------|--|--|
| • 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.)

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| • Acupuncture - 60 visits per <u>plan</u> year | • Routine eye care (Adult) - 1 exam per <u>plan</u> year | • Spinal manipulation - 60 visits per <u>plan</u> year |
| • Hearing aids - \$5,000 per every 36 months | | |

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 Kansas Insurance Department at 1-800-432-2484 or www.ksinsurance.org. Additionally, a consumer assistance program can help you file your appeal. Contact Kansas Insurance Department 1-800-432-2484 or visit www.ksinsurance.org.

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, kwijjigo 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 <u>plan's overall deductible</u>	\$0
■ <u>Specialist copayment</u>	\$25 - \$130
■ <u>Hospital (facility) copayment</u>	\$350 - \$3,500
■ <u>Other coinsurance</u>	\$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
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1300
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$1360

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's overall deductible</u>	\$0
■ <u>Specialist copayment</u>	\$25 - \$130
■ <u>Hospital (facility) copayment</u>	\$350 - \$3,500
■ <u>Other coinsurance</u>	\$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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$0
The total Joe would pay is	\$600

Mia's Simple Fracture

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

■ The <u>plan's overall deductible</u>	\$0
■ <u>Specialist copayment</u>	\$25 - \$130
■ <u>Hospital (facility) copayment</u>	\$350 - \$3,500
■ <u>Other coinsurance</u>	\$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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1600
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$1600

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