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: $4,000 individual / $8,000 family For out-of-network providers: $8,000 individual / $16,000 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 In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information*
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 - $40 copayment/visit	$120 copayment/visit	Certain procedures performed in the office may have a higher office visit copayment. 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. Virtual visits (Primary and Urgent) - No charge per visit by a Designated Virtual Network Providers. Virtual visits (Specialty) - $0 - $40 copayment per visit by a Designated Virtual Network Providers. *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	$5 - $40 copayment/visit	$120 copayment/visit	
	Preventive care/screening/ immunization	No charge	$60 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	**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:** $5 - $450 copayment/visit	**Routine diagnostic test:** No charge **Non-routine diagnostic test:** Up to $1,350 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. Prior authorization is required for certain Non-routine diagnostic tests or there may be no coverage.
	Imaging (CT/PET scans, MRIs)	$40 - $280 copayment/visit	$750 - $840 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. 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 In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com.	**Tier 1 drugs**	Not covered	Not covered	To learn more about drug tiers and about copayments for specific drugs, visit www.caremark.com.
	Tier 2 drugs	Not covered	Not covered	
	Tier 3 drugs	Not covered	Not covered	
	Specialty drugs	Not covered	Not covered	

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information*
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$10 - $2,000 copayment/visit	Up to $6,000 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. 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	$180 copayment/visit	$180 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	$80 copayment/transport	$80 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	$20 copayment/visit	$60 copayment/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$75 - $2,000 copayment/stay	Up to $6,000 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 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 In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Home/Office**: $5 copayment/visit **Outpatient Facility**: $50 copayment/visit	**Home/Office**: $60 copayment/visit **Outpatient Facility**: $150 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	$1,000 copayment/stay	$3,000 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	$60 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	$350 - $1,000 copayment/stay	$3,000 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 In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information*
If you need help recovering or have other special health needs	Home health care	$15 copayment/visit	$45 copayment/visit	100 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	$5 - $35 copayment/visit	Up to $105 copayment/visit	60 visit limit for occupational therapy 60 visit limit for physical therapy 40 visit limit for speech therapy Visit limits are a combination of network providers and out-of-network providers per person per plan year. 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	$5 - $35 copayment/visit	Up to $105 copayment/visit	
	Skilled nursing care	$800 copayment/stay	$2,400 copayment/stay	100 day limit per person per plan year. Prior authorization is required or there may be no coverage.
	Durable medical equipment	$0 - $500 copayment/ equipment based on DME tier	Up to $1,000 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**: $15 copayment/visit **Inpatient**: $1,000 copayment/stay	**Home**: $45 copayment/visit **Inpatient**: $3,000 copayment/stay	None
If your child needs dental or eye care	Children's eye exam	No charge	$120 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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

Other Covered Services (Limitations may apply to th se services. This isn't a complete list. Plea e see your plan document.)

- Bariatric surgery
- Chiropractic care (12 visit limit per person per plan year)
- Infertility treatment (limitations apply)
- Private duty nursing (82 visit limit per person per plan year)
- 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 the agency is the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or www.cms.gov/cciio. 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 1-866-683-6440.

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** **$5**
- **Hospital (facility) copayment** **$1,000**
- **Other copayments** **$5**

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	$1,100
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$70**
The total Peg would pay is	**$1,170**

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** **$5**
- **Hospital (facility) copayment** **$1,000**
- **Other copayments** **$5**

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	$50
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$4,300**
The total Joe would pay is	**$4,350**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$5**
- **Hospital (facility) copayment** **$1,000**
- **Other copayments** **$5**

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	$400
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$10**
The total Mia would pay is	**$410**

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

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

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