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, copay, 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
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 copay or coinsurance may apply.	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. 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 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 copay 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	$15 - $100 copay/visit	$300 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. Virtual visits – $0 to $100 copay per visit by a Designated Virtual Network Provider. *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	$15 - $100 copay/visit	$300 copay/visit	
	Preventive care/screening/ immunization	No charge	$150 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 (e.g. x-ray, blood work)	**Routine diagnostic test:** No charge **Non-routine diagnostic test**: $10 - $1,100 copay/visit	**Routine diagnostic test:** No charge **Non-routine diagnostic test**: Up to $3,300 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 is required for certain non-routine diagnostic tests or your benefits may be reduced or there may be no coverage.
	Imaging (CT/PET scans, MRIs)	$100 - $700 copay/visit	Up to $2,100 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 is required for certain imaging tests or your benefits may be reduced or there may be no coverage.

*For more information about limitations and exceptions, see plan or policy document at Join.Surest.com for prospective members.

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 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 drugs	**30-Day Supply** $60 copay **90-Day Supply** $150 copay	Not covered	
	Tier 3 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.

*For more information about limitations and exceptions, see plan or policy document at Join.Surest.com for prospective members.

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 - $3,000 copay/visit	Up to $9,000 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 is required for certain outpatient surgery or your benefits may be reduced or there may be no coverage.
	Physician/surgeon fees	No charge	No charge	
If you need immediate medical attention	Emergency room care	$500 copay/visit	$500 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	$250 copay/transport	$250 copay/transport	Out-of-network emergency medical transportation copay applies to the in-network out-of-pocket limit.
	Urgent care	$50 copay/visit	$150 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 is required for non-emergency facility admissions and inpatient surgery or your benefits may be reduced or there may be no coverage.
	Physician/surgeon fees	No charge	No charge	

*For more information about limitations and exceptions, see plan or policy document at Join.Surest.com for prospective members.

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**: $15 copay/visit **Outpatient Facility**: $125 copay/visit	**Home/Office**: $150 copay/visit **Outpatient Facility**: $375 copay/visit	Certain procedures/services in the outpatient setting may have a lower copay. Preauthorization is required for certain outpatient services or your benefits may be reduced or there may be no coverage.
	Inpatient services	$2,000 copay/stay	$6,000 copay/stay	Certain procedures/services in the inpatient setting may have a lower copay. Preauthorization is required for certain inpatient services or your benefits may be reduced or there may be no coverage.
If you are pregnant	Office visits	No charge	$150 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 is required for inpatient stays beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery or your benefits may be reduced or there may be no coverage.
	Childbirth/delivery facility services	$900 - $2,000 copay/stay	$6,000 copay/stay	

*For more information about limitations and exceptions, see plan or policy document at Join.Surest.com for prospective members.

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	$45 copay/visit	$100 copay/visit	Limited to 120 visits per person per plan year. Preauthorization is required for certain home health care services or your benefits may be reduced or there may be no coverage.
	Rehabilitation services	$15 - $95 copay/visit	Up to $285 copay/visit	Limits per person per plan year: Occupational, physical and speech therapy: 60 visits each. 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. For mental health related therapies, see Section 1: Covered Health Care Services*.
	Habilitation services	$15 - $95 copay/visit	Up to $285 copay/visit	
	Skilled nursing care	$1,500 copay/stay	$4,500 copay/stay	Limited to 120 days per person per plan year. Preauthorization is required or your benefits may be reduced or there may be no coverage.
	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 is required for certain DME or your benefits may be reduced or there may be no coverage.
	Hospice services	**Home:** $45 copay/visit **Inpatient:** $2,000 copay/stay	**Home**: $135 copay/visit **Inpatient:** $6,000 copay/stay	None.
If your child needs dental or eye care	Children's eye exam	No Charge	$300 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.

*For more information about limitations and exceptions, see plan or policy document at Join.Surest.com for prospective members.

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.)

- Bariatric surgery
- Cosmetic surgery
- Dental Care (Adult)
- Infertility treatment
- 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
- Chiropractic care
- Hearing aids (Limitations apply)
- Routine Eye Care (Adult) (Limited to 1 exam every 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 www.dol.gov/ebsa/healthreform or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or the Ohio Department of Insurance at 800-686-1526 or www.insurance.ohio.gov.

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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
• The plan's overall deductible	$0	• The plan's overall deductible	$0	• The plan's overall deductible	$0
• Specialist copayment	$15	• Specialist copayment	$15	• Specialist copayment	$15
• Hospital (facility) copayment	$200 - $3,000	• Hospital (facility) copayment	$200 - $3,000	• Hospital (facility) copayment	$200 - $3,000
• Other coinsurance	$0	• Other coinsurance	$0	• Other coinsurance	$0
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)*		**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)*		**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	**$12,700**	**Total Example Cost**	**$5,600**	**Total Example Cost**	**$2,800**
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost sharing		*Cost sharing*		*Cost sharing*	
Deductibles	$0	Deductibles	$0	Deductibles	$0
Copayments	$5,000	Copayments	$1,300	Copayments	$1,200
Coinsurance	$0	Coinsurance	$0	Coinsurance	$0
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$60	Limits or exclusions	$20	Limits or exclusions	$0
The total Peg would pay is	**$5,060**	The total Joe would pay is	**$1,320**	The total Mia would pay is	**$1,200**

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.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية (Summary of Benefits and Coverage، SBC) هذا.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。
本「保障および給付の概要」(Summary of Benefits and Coverage, SBC)に記載されているフリー
ダイヤルにてお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به‌طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage، SBC) تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការគ្របដណ្តប់ (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).