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 or call 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 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. Preventive Care.	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 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: Not applicable	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 (use access code **ArchdioceseNY2026**)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	$20 - $105 copay/visit	Not Covered	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. *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	Not Covered	
	Preventive care/screening/ immunization	No charge	Not Covered	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**:** $20 - $1,300 copay/visit	**Routine** diagnostic test**:** No charge **Non-routine** diagnostic test**:** Not Covered	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. Prior authorization is required for certain Non-routine diagnostic tests or there may be no coverage.
	Imaging (CT/PET scans, MRIs)	$100 - $1,400 copay/visit	Not Covered	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. 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.

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 More information about prescription drug coverage is available at Caremark.com or call 1-800-565-7091	**Tier 1 – Your Lowest Cost Option**	Retail: $10 copay Mail-Order: $20 copay	Not covered	Provider means pharmacy for purpose of this section. Retail: Up to a 30 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by Caremark. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail-order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Separate RX out-of-pocket maximum of $3,000 for an individual and $6,000 for family. Tier 4 Specialty Drugs as approved by CVS Prudent Rx program will be covered at $0 copay if the member us enrolled in the Prudent Rx program. If not enrolled, the member will be subject to 30% coinsurance of the cost of the drug.
	Tier 2 – Your Mid-Range Cost Option	Retail: $25 copay Mail-Order: $50 copay	Not covered	
	Tier 3 – Your Mid-Range Cost Option	Retail: $50 copay Mail-Order: $100 copay	Not covered	
	Tier 4 – Your Highest Cost Option	CVS Specialty Pharmacy $0 copay or 30% coinsurance	Not covered	

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)	$35 - $3,000 copay/visit	Not covered	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. Prior authorization is required for certain outpatient surgery or there may be no coverage.
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	$650 copay/visit	$650 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	$375 copay/transport	$375 copay/transport	Prior authorization is required for non-emergency medical transportation or there may be no coverage. Out-of-network emergency medical transportation copay applies to the in-network out-of-pocket limit.
	Urgent care	$60 copay/visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 - $3,000 copay/stay	Not covered	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. Prior authorization is required for non-emergency facility admissions and inpatient surgery or there may be no coverage.
	Physician/surgeon fees	No charge	Not covered	

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

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**: $20 copay/visit **Outpatient Facility**: $110 copay/visit	Not covered	Certain procedures/services in the outpatient setting may have a lower copay. Prior authorization is required for certain outpatient services or there may be no coverage.
	Inpatient services	$1,600 copay/stay	Not covered	Certain procedures/services in the inpatient setting may have a lower copay. Prior authorization is required for certain inpatient services or there may be no coverage.
If you are pregnant	Office visits	No charge	Not covered	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	Not covered	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. Cost sharing does not apply to certain preventive services. 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	$900 - $2,000 copay/stay	Not covered	

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 copay/visit	Not covered	200 visit limit per person per plan year. Prior authorization is required for certain home health care services or there may be no coverage.
	Rehabilitation services	$10 - $140 copay/visit	Not covered	90 visit limit for physical therapy, occupational therapy, restorative speech therapy, pulmonary rehabilitation therapy and cardiac rehabilitation therapy. Visit limits are 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 - $140 copay/visit	Not covered	
	Skilled nursing care	$1,500 copay/stay	Not covered	120 day limit per person per plan year. Prior authorization is required or there may be no coverage.
	Durable medical equipment	$0 - $1,000 copay/equipment based on DME tier	Not covered	Prior authorization is required for certain DME or there may be no coverage.
	Hospice services	**Home**: $60 copay/visit **Inpatient**: $2,000 copay/stay	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	None
	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 Surest.Care/ServiceNow.

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.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- 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 (20 visit limit per person per plan year)
- Bariatric surgery
- Chiropractic care (60 visit limit per person per plan year)
- Routine eye care (Adult)
- 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 **[**1-866-633-2446**]**.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 **[**1-866-633-2446**]**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **[**1-866-633-2446**]**.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf **[**1-866-633-2446**]** uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **[**1-866-633-2446**]**.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni **[**1-866-633-2446**]**.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye **[**1-866-633-2446**]**.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang **[**1-866-633-2446**]**.

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 (*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	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$970**

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	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,000**

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 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	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,210**

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