



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, call 1-855-275-1400 or visit <https://www.networkhealth.com/assets/pdf/individual-benefits-2026/individualpolicy.pdf>. 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://www.healthcare.gov/sbc-glossary> or call 1-855-275-1400 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                              | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$0                                                                                                                                                                                                                                                  | See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Certain <a href="#">preventive services</a> , office visits, tests and prescription drugs are covered before you meet your <a href="#">deductible</a> . See the specific services listed below denoted ' <a href="#">Deductible</a> does not apply'. | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> |
| Are there other <a href="#">deductibles</a> for specific services?              | Yes. Prescription Drugs Tiers 3, 4 and 5 \$1,500 member/ \$3,000 family. There are no other specific <a href="#">deductibles</a> .                                                                                                                   | You don't have to meet <a href="#">deductibles</a> for specific services. You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.                                                                                                                                                                                                                                                                                                                                                |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$9,200 member / \$18,400 family                                                                                                                                                                                                                     | The <a href="#">out-of-pocket limit</a> 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 <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                      |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Premiums, health care this plan doesn't cover, denied benefits, balance billing charges, the benefit reduction amount when prior authorization is not obtained.                                                                                      | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.networkhealth.com">www.networkhealth.com</a> or call Network Health Customer                                                                                                                                            | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">Out-of-network</a> provider, and you might receive a bill from                                                                                                                                                                                                                                                                                                                |

| Important Questions                                                          | Answers                                                                              | Why This Matters:                                                                                                                                                                                                                                                                                                                                                   |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                              | Service at 1-855-275-1400 for a listing of participating <a href="#">providers</a> . | a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (balance billing). Be aware, your <a href="#">network provider</a> might use an <a href="#">Out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No.                                                                                  | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                          |

 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<br>(You will pay the least)               | Out of-Network<br>Provider (You will pay the most) |                                                                                                                                                                                                                                                   |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                                     | Primary care visit to treat an injury or illness       | \$45/visit                                                 | Not Covered                                        | None                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                            | <a href="#">Specialist</a> visit                       | \$150/visit                                                | Not Covered                                        | None                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                            | <a href="#">Preventive care/screening/immunization</a> | No Charge                                                  | Not Covered                                        | Ask your <a href="#">provider</a> if the services needed are preventive.                                                                                                                                                                          |
| If you have a test                                                                                                                                                                                         | <a href="#">Diagnostic test</a> (x-ray, blood work)    | \$75/visit for lab<br>\$150/visit for x-ray                | Not Covered                                        | Full coverage if required by federal law.                                                                                                                                                                                                         |
|                                                                                                                                                                                                            | Imaging (CT/PET scans, MRIs)                           | \$500/visit                                                | Not Covered                                        | <a href="#">Preauthorization</a> is required.                                                                                                                                                                                                     |
|                                                                                                                                                                                                            |                                                        |                                                            |                                                    |                                                                                                                                                                                                                                                   |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.networkhealth.com">www.networkhealth.com</a> | Generic drugs Tier 1                                   | \$30/retail Rx or refill or \$75/mail order Rx or refill   | Not Covered                                        | Certain generics are available for a \$0 Retail <a href="#">copayment</a> or a \$0 Mail Order <a href="#">copayment</a> . Refer to your formulary. Covers up to a 30-day supply (retail prescription); 30-90 day supply (mail order prescription) |
|                                                                                                                                                                                                            | Preferred brand drugs Tier 2                           | \$160/retail Rx or refill or \$400/mail order Rx or refill | Not Covered                                        | Covers up to a 30-day supply (retail prescription); 30-90 day supply (mail order prescription)                                                                                                                                                    |
|                                                                                                                                                                                                            | Non-preferred brand drugs Tier 3                       | 50% <a href="#">coinsurance</a> retail Rx or refill or     | Not Covered                                        | Covers up to a 30-day supply (retail prescription); 30-90 day supply (mail order prescription)                                                                                                                                                    |

| Common Medical Event                                                      | Services You May Need                                | What You Will Pay                                                         |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                   |
|---------------------------------------------------------------------------|------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                      | Network Provider<br>(You will pay the least)                              | Out of-Network<br>Provider (You will pay the most) |                                                                                                                                                                                                                                                          |
|                                                                           |                                                      | 50% <a href="#">coinsurance</a> mail order Rx or refill                   |                                                    |                                                                                                                                                                                                                                                          |
|                                                                           | Preferred <a href="#">Specialty drugs</a> Tier 4     | 40% <a href="#">coinsurance</a> retail Rx or refill at specialty pharmacy | Not Covered                                        | Covers up to a 30-day supply (specialty pharmacy); No mail order                                                                                                                                                                                         |
|                                                                           | Non-Preferred <a href="#">Specialty drugs</a> Tier 5 | 50% <a href="#">coinsurance</a> retail Rx or refill at specialty pharmacy | Not Covered                                        | Covers up to a 30-day supply (specialty pharmacy); No mail order                                                                                                                                                                                         |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)       | \$150/visit                                                               | Not Covered                                        | None                                                                                                                                                                                                                                                     |
|                                                                           | Physician/surgeon fees                               | \$150/visit                                                               | Not Covered                                        | None                                                                                                                                                                                                                                                     |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>                  | \$2,000/visit                                                             | \$2,000/visit                                      | <a href="#">Copayment</a> waived if admitted inpatient within 24 hours                                                                                                                                                                                   |
|                                                                           | <a href="#">Emergency medical transportation</a>     | \$150/transport                                                           | \$150/transport                                    | None                                                                                                                                                                                                                                                     |
|                                                                           | <a href="#">Urgent care</a>                          | \$75/visit                                                                | \$75/visit                                         | Services provided by an Out-of-network facility are covered only when received outside the service area. Services received at an Out-of-network non-Hospital-based Urgent Care Facility require that Network Health be notified within one business day. |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)                   | \$1,500/day ,days 1-2                                                     | Not Covered                                        | <a href="#">Preauthorization</a> is required.                                                                                                                                                                                                            |
|                                                                           | Physician/surgeon fees                               | \$150/visit                                                               | Not Covered                                        | None                                                                                                                                                                                                                                                     |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                                  | \$45/visit                                                                | Not Covered                                        | None                                                                                                                                                                                                                                                     |
|                                                                           | Inpatient services                                   | \$1,500/day ,days 1-2                                                     | Not Covered                                        | <a href="#">Preauthorization</a> is required.                                                                                                                                                                                                            |
| If you are pregnant                                                       | Office visits                                        | No Charge                                                                 | Not Covered                                        | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC.                                                                                      |

| Common Medical Event                                                  | Services You May Need                     | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                     |
|-----------------------------------------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                           | Network Provider<br>(You will pay the least) | Out of-Network<br>Provider (You will pay the most) |                                                                                                                                                                                                            |
|                                                                       | Childbirth/delivery professional services | \$150/visit                                  | Not Covered                                        | None                                                                                                                                                                                                       |
|                                                                       | Childbirth/delivery facility services     | \$1,500/day ,days 1-2                        | Not Covered                                        | <a href="#">Preauthorization</a> is required.                                                                                                                                                              |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | No Charge                                    | Not Covered                                        | Limited to 60 visits per benefit year. <a href="#">Preauthorization</a> is required.                                                                                                                       |
|                                                                       | <a href="#">Rehabilitation services</a>   | \$75/visit                                   | Not Covered                                        | Limited to 20 visits each per benefit year for Physical, Occupational, Speech and Pulmonary Therapy. Cardiac Rehab is limited to 36 visits per benefit year. <a href="#">Preauthorization</a> is required. |
|                                                                       | <a href="#">Habilitation services</a>     | \$75/visit                                   | Not Covered                                        | Limited to 20 visits each per benefit year for Physical, Occupation and Speech Therapy                                                                                                                     |
|                                                                       | <a href="#">Skilled nursing care</a>      | \$1,500/day ,days 1-5                        | Not Covered                                        | Limited to 30 days per benefit year. <a href="#">Preauthorization</a> is required.                                                                                                                         |
|                                                                       | <a href="#">Durable medical equipment</a> | \$150/visit                                  | Not Covered                                        | Limited to 20 DME devices/items per year, whether rented or purchased as indicated in the Policy. <a href="#">Preauthorization</a> is required.                                                            |
|                                                                       | <a href="#">Hospice services</a>          | No Charge                                    | Not Covered                                        | <a href="#">Preauthorization</a> is required.                                                                                                                                                              |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | No Charge                                    | Not Covered                                        | Limited to one Routine Eye Exam per 12 month period.                                                                                                                                                       |
|                                                                       | Children's glasses                        | No Charge                                    | Not Covered                                        | None                                                                                                                                                                                                       |
|                                                                       | Children's dental check-up                | Not Covered                                  | Not Covered                                        | None                                                                                                                                                                                                       |

## 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](#).)

- |                     |                                                               |                            |
|---------------------|---------------------------------------------------------------|----------------------------|
| • Abortion          | • Infertility Treatment                                       | • Private-duty nursing     |
| • Acupuncture       | • Long-term care                                              | • Routine eye care (Adult) |
| • Bariatric surgery | • Non-emergency care when traveling outside the United States | • Routine foot care        |
| • Cosmetic Surgery  | • Oral Surgery                                                | • Weight loss programs     |
| • Dental care       |                                                               |                            |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |                     |                |
|---------------------|----------------|
| • Chiropractic care | • Hearing aids |
|---------------------|----------------|

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), Department of Health and Human Services Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov), or you may contact Network Health Member Experience Team at 1-855-275-1400 for more information. 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](http://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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or you may contact Network Health Member Experience Team at 1-855-275-1400 for more information.

### 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](#).

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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 prenatal care and a hospital delivery)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0   |
| ■ <a href="#">Specialist copayment</a>                          | \$150 |
| ■ Hospital (facility)                                           |       |
| ■ Other <a href="#">copayment</a>                               | \$75  |

#### 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*)

|                                        |                 |
|----------------------------------------|-----------------|
| <b>Total Example Cost</b>              | <b>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| <a href="#">Deductibles</a>            | \$0             |
| <a href="#">Copayments</a>             | \$1,900         |
| <a href="#">Coinsurance</a>            | \$0             |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$60            |
| <b>The total Peg would pay is</b>      | <b>\$1,960</b>  |

### Managing Joe's Type 2 Diabetes

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

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0   |
| ■ <a href="#">Specialist copayment</a>                          | \$150 |
| ■ Hospital (facility)                                           |       |
| ■ Other <a href="#">copayment</a>                               | \$75  |

#### 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*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$5,600</b> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$0            |
| <a href="#">Copayments</a>             | \$1,600        |
| <a href="#">Coinsurance</a>            | \$0            |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$20           |
| <b>The total Joe would pay is</b>      | <b>\$1,620</b> |

### Mia's Simple Fracture

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0     |
| ■ <a href="#">Specialist copayment</a>                          | \$150   |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$2,000 |
| ■ Other <a href="#">copayment</a>                               | \$75    |

#### This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$2,800</b> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$0            |
| <a href="#">Copayments</a>             | \$1,300        |
| <a href="#">Coinsurance</a>            | \$0            |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$1,300</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.