



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 visit 1-855-275-1400 or visit www.networkhealth.com/assets/pdf/individual-benefits-2025/individualpolicy.pdf. For general definitions of common terms, such [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at www.networkhealth.com or call 1-855-275-1400 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 ? | No. Preventive care , office visits, tests, immediate medical and drugs may be covered before you meet your deductible . See the specific services listed below denoted Deductible does not apply. | 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://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 ? | Not Applicable | This plan does not have an out-of-pocket limit on your expenses. |
| What is not included in the out-of-pocket limit ? | Non-covered services, denied benefits, and the benefit reduction amount when prior authorization is not obtained. Certain specialty drugs that are considered non-essential health benefits. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . Certain specialty drugs that are considered non essential will be reimbursed by the manufacturer at cost to you. |

| Important Questions | Answers | Why This Matters: |
|--|--|--|
| Will you pay less if you use a network provider ? | Yes. See networkhealth.com or call Network Health Customer Service at 1-855-275-1400 for a listing of participating 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 . |



| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|-------------------------|---|
| | | In Network (You will pay the least) | (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 | No Charge | Not Covered | First three visits covered at No Charge: combined with behavioral health, substance abuse, and maternity office visits. |
| | Specialist visit | No Charge | Not Covered | None |
| | Preventive care/screening /immunization | No Charge | Not Covered | Ask your provider if the services needed are preventive. |
| If you have a test | Diagnostic test (x-ray, blood work) | No Charge | Not Covered | Full coverage if required by federal law. |
| | Imaging (CT/PET scans, MRIs) | No Charge | Not Covered | None |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.networkhealth.com | Generic drugs | No Charge (retail/mail order) | Not Covered | Certain generics are available for a \$0 Retail Copayment or a \$0 Mail Order Copayment . Refer to your formulary. Covers up to a 30-day supply (retail prescription); 30-90 day supply (mail order prescription) |
| | Preferred brand drugs | No Charge (retail/mail order) | Not Covered | Covers up to a 30-90 day supply, Copay per 30-day supply (retail prescription); 30-90 day supply (mail order prescription) |
| | Non-preferred brand drugs | No Charge (retail/mail) | Not Covered | Covers up to a 30-90 day supply, |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|---|---|
| | | In <u>Network</u> (You will pay the least) order) | (You will pay the most) | |
| | | | | Copay per 30-day supply (retail prescription); 30-90 day supply (mail order prescription) |
| | <u>Specialty drugs</u> | No Charge | Not Covered | Covers up to a 30-day supply (specialty pharmacy); No mail order Please see "Important questions" regarding the plan's out of pocket limit |
| | Non-preferred <u>Specialty drugs</u> | No Charge | Not Covered | Covers up to a 30-day supply (specialty pharmacy); No mail order Please see "Important questions" regarding the plan's out of pocket limit |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No Charge | Not Covered | None |
| | Physician/surgeon fees | No Charge | Not Covered | None |
| If you need immediate medical attention | Emergency room care | No Charge | No Charge | None |
| | Emergency medical transportation | No Charge | No Charge | None |
| | Urgent care | No Charge | \$0 / visit ; deductible does not apply | Services are covered only when Outside the Service Area and only when furnished by a Hospital-based Urgent Care Facility |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No Charge | Not Covered | Preauthorization is required |
| | Physician/surgeon fees | No Charge | Not Covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No Charge and No Charge other outpatient services. | Not Covered | First three visits covered at No Charge: combined with behavioral health, substance abuse, and maternity office visits. |
| | Inpatient services | No Charge | Not Covered | Preauthorization is required |
| If you are pregnant | Office visits | No Charge | Not Covered | None |
| | Childbirth/delivery professional services | No Charge | Not Covered | None |
| | Childbirth/delivery facility services | No Charge | Not Covered | Maternity care may include tests and services described elsewhere in the |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|-------------------------|--|
| | | In <u>Network</u> (You will pay the least) | (You will pay the most) | |
| | | | | SBC. |
| If you need help recovering or have other special health needs | Home health care | No Charge | Not Covered | Limited to 60 visits per benefit year; Preauthorization is required |
| | Rehabilitation services | No Charge | Not Covered | Limited to 20 visits each per benefit year for Physical/Occupational/Speech/Pulmonary Therapy; Cardiac Rehab is limited to 36 visits per benefit year. |
| | Habilitation services | No Charge | Not Covered | Limited to 20 visits each per benefit year for Physical, Occupation and Speech Therapy |
| | Skilled nursing care | No Charge | Not Covered | Limited to 30 days per benefit year, Preauthorization is required |
| | Durable medical equipment | No Charge | Not Covered | None Limited to 20 DME devices/items per year, whether rented or purchased as indicated in the Policy. |
| | Hospice services | No Charge | Not Covered | Preauthorization is required |
| If your child needs dental or eye care | 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 | Only Frames from a pediatric exchange collection are covered |
| | Children's dental check-up | No Charge | Not Covered | Reimbursement for One exam, cleaning, and bite-wing x-ray per 12 months. |

Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) | | |
|--|--|---|
| <ul style="list-style-type: none"> • Abortion • Acupuncture • Bariatric surgery | <ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the | <ul style="list-style-type: none"> • Private-duty nursing • Routine foot care • Weight loss programs |

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- U.S.
- Oral Surgery

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

- Chiropractic care
- Hearing aids
- Routine eye care (Adult)
- Dental care (Adult)

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, Department of Health and Human Services Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov, or you may contact Network Health Member Experience Team at 1-800-826-0940 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 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, or you may contact Network Health Member Experience Team at 1-800-826-0940 for more information.

Does this plan provide Minimum Essential Coverage?

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?

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 plan's overall deductible \$0
- Specialist \$0
- Hospital (facility) \$0
- Other \$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: | |
| <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$60 |

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 \$0
- Hospital (facility) \$0
- Other \$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: | |
| <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$20 |

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

- The plan's overall deductible \$0
- Specialist \$0
- Hospital (facility) \$0
- Other \$0

This EXAMPLE event includes services like:

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

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

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-855-275-1400.

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