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?	$5,000 member / $10,000 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. 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?	$8,000 member / $16,000 family	The out-of-pocket limit is the most you could pay in a year for covered services.If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	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 In Network (You will pay the least)	What You Will Pay (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 / visit; deductible does not apply	Not Covered	None
	Specialist visit	$80 / visit; deductible does not apply	Not Covered	None
	Preventive care/screening/immunization	No Charge; deductible does not apply	Not Covered	Ask your provider if the services needed are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance for Lab 40% coinsurance for X-ray	Not Covered	Full coverage if required by federal law.
	Imaging (CT/PET scans, MRIs)	40% coinsurance	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	$20 Copayment per Rx or refill retail or $60 Copayment per Rx or refill mail order.; deductible does not apply	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	$40 Copayment per Rx or refill retail or $120 Copayment per Rx or refill mail	Not Covered	Covers up to a 30-90 day supply, Copay per 30-day suppy (retail prescription); 30-90 day supply (mail

Common Medical Event	Services You May Need	What You Will Pay In Network (You will pay the least)	What You Will Pay (You will pay the most)	Limitations, Exceptions, & Other Important Information
		order.; deductible does not apply		order prescription)
	Non-preferred brand drugs	$80 Copayment per Rx or refill retail or $240 Copayment per Rx or refill mail order.	Not Covered	Covers up to a 30-90 day supply, Copay per 30-day suppy (retail prescription); 30-90 day supply (mail order prescription)
	Specialty drugs	$350 Copayment per Rx or refill at specialty pharmacy and no mail order.	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 Specialty drugs	$350 Copayment per Rx or refill at specialty pharmacy and no mail order.	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)	40% coinsurance	Not Covered	None
	Physician/surgeon fees	40% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	None
	Emergency medical transportation	40% coinsurance	40% coinsurance	None
	Urgent care	$60 / visit; deductible does not apply	$60 / 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)	40% coinsurance	Not Covered	Preauthorization is required
	Physician/surgeon fees	40% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 / per office visit; deductible does not apply and 40% coinsurance other outpatient services.	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay In Network (You will pay the least)	What You Will Pay (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Inpatient services	40% coinsurance	Not Covered	Preauthorization is required
If you are pregnant	Office visits	40% coinsurance	Not Covered	None
	Childbirth/delivery professional services	40% coinsurance	Not Covered	None
	Childbirth/delivery facility services	40% coinsurance	Not Covered	Maternity care may include tests and services described elsewhere in the SBC.
If you need help recovering or have other special health needs	Home health care	40% coinsurance	Not Covered	Limited to 60 visits per benefit year; Preauthorization is required
	Rehabilitation services	$40 / visit; deductible does not apply	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	40% coinsurance	Not Covered	Limited to 20 visits each per benefit year for Physical, Occupation and Speech Therapy
	Skilled nursing care	40% coinsurance	Not Covered	Limited to 30 days per benefit year, Preauthorization is required
	Durable medical equipment	40% coinsurance	Not Covered	Limited to 20 DME devices/items per year, whether rented or purchased as indicated in the Policy.
	Hospice services	40% ; deductible does not apply coinsurance	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	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
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Oral Surgery
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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, 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	$5,000
Specialist copayment	$80
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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	$5,000
Copayments	$0
Coinsurance	$3,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$8,060**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$5,000
Specialist copayment	$80
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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	$900
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

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

The plan's overall deductible	$5,000
Specialist copayment	$80
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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:	
Cost Sharing	
Deductibles	$1,700
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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.