



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](http://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](http://www.networkhealth.com) 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> ?	No. <a href="#">Preventive care</a> , office visits, tests, immediate medical and drugs may be 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?	No.	You don't have to meet deductibles for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$9,100 member / \$18,200 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> ?	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 <a href="#">out-of-pocket limit</a> . 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 <a href="#">network provider</a> ?	Yes. See <a href="http://networkhealth.com">networkhealth.com</a> or call Network Health Customer Service at 1-855-275-1400 for a listing of participating <a href="#">providers</a> .	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 <a href="#">Out of network</a> provider, and you might receive a bill from a provider for the difference between the provider's charge and what your <a href="#">plan</a> pays (balance billing). Be aware, your network provider might use an <a href="#">Out of network</a> provider for some services (such as lab work). Check with your provider 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> .



Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In <a href="#">Network</a> (You will pay the least)	(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	\$55 / visit	Not Covered	None
	<a href="#">Specialist</a> visit	\$150 / visit	Not Covered	None
	<a href="#">Preventive care/screening</a> /immunization	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 per lab visit \$150 per X-ray visit	Not Covered	Full coverage if required by federal law.
	Imaging (CT/PET scans, MRIs)	\$500 / visit	Not Covered	None
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.networkhealth.com">www.networkhealth.com</a>	Generic drugs	\$30 <a href="#">Copayment</a> per Rx or refill retail or \$75 <a href="#">Copayment</a> per Rx or refill mail order.	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	\$160 <a href="#">Copayment</a> per Rx or refill retail or \$400 <a href="#">Copayment</a> per Rx or refill 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	50% <a href="#">coinsurance</a> (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)

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)	
	<u>Specialty drugs</u>	40% <a href="#">coinsurance</a>	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>	50% <a href="#">coinsurance</a>	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
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$150 / visit	Not Covered	None
	Physician/surgeon fees	\$150 / visit	Not Covered	None
<b>If you need immediate medical attention</b>	<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 / visit	\$150 / visit	None
	<a href="#">Urgent care</a>	\$75 / visit	\$75 / visit ; <a href="#">deductible</a> does not apply	Services are covered only when Outside the Service Area and only when furnished by a Hospital-based Urgent Care Facility
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$1,500 / day	Not Covered	Preauthorization is required
	Physician/surgeon fees	\$55 / visit	Not Covered	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$55 / per office visit and other outpatient services.	Not Covered	None
	Inpatient services	\$1,500 / day	Not Covered	Preauthorization is required
<b>If you are pregnant</b>	Office visits	\$55 / visit	Not Covered	None
	Childbirth/delivery professional services	\$55 / visit	Not Covered	None
	Childbirth/delivery facility services	No Charge	Not Covered	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
		In <u>Network</u> (You will pay the least)	(You will pay the most)	
<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; Preauthorization is required
	<a href="#">Rehabilitation services</a>	\$75 / visit	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.
	<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 / visit	Not Covered	Limited to 30 days per benefit year, Preauthorization is required
	<a href="#">Durable medical equipment</a>	\$150 / visit	Not Covered	None Limited to 20 DME devices/items per year, whether rented or purchased as indicated in the Policy.
	<a href="#">Hospice services</a>	No Charge	Not Covered	Preauthorization 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 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"> <li>• Abortion</li> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>

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

- Oral Surgery

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

- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Routine eye 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](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 1-800-826-0940 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](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 1-800-826-0940 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 copayment \$150
- Hospital (facility) \$0
- Other copayment \$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>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$4,000
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,060</b>

**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 \$150
- Hospital (facility) copayment \$150
- Other copayment \$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>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,700
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,720</b>

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

- The plan's overall deductible \$0
- Specialist copayment \$150
- Hospital (facility) copayment \$2,000
- Other copayment \$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>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,300</b>

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.