



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 deductible? | \$7,750 member / \$15,500 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. Certain preventive services , office visits, tests and prescription drugs are 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? | \$9,500 member / \$19,000 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? | 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 out-of-pocket limit . |
| Will you pay less if you use a network provider? | Yes. See www.networkhealth.com or call Network Health Customer | 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 |

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| | Service at 1-855-275-1400 for a listing of participating providers . | 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 |
|--|--|---|--|--|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP 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 | No Charge | \$55/visit; deductible does not apply | Not Covered | First three visits covered at No Charge; combined with behavioral health, substance abuse and maternity office visits. |
| | Specialist visit | No Charge | \$110/visit; deductible does not apply | Not Covered | None |
| | Preventive care/screening/immunization | No Charge | 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 | \$55/visit for lab; deductible does not apply \$60/visit for x-ray | Not Covered | Full coverage if required by federal law. |
| | Imaging (CT/PET scans, MRIs) | No Charge | 50% coinsurance | Not Covered | Preauthorization is required. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is | Generic drugs Tier 1 | No Charge (retail or mail order Rx or refill) | \$30/retail Rx or refill or \$70/mail order Rx or refill ; 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) |

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| available at www.networkhealth.com | Preferred brand drugs Tier 2 | No Charge (retail or mail order Rx or refill) | \$80/retail Rx or refill or \$225/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 | No Charge (retail or mail order Rx or refill) | 50% <u>coinsurance</u> retail Rx or refill or 50% <u>coinsurance</u> mail order Rx or refill | Not Covered | Covers up to a 30-day supply (retail prescription); 30-90 day supply (mail order prescription) |
| | Preferred <u>Specialty drugs</u> Tier 4 | Not Covered | \$0/ retail RX or refill at specialty pharmacy; <u>deductible</u> does not apply | Not Covered | Covers up to a 30-day supply (specialty pharmacy); No mail order |
| | Non-Preferred <u>Specialty drugs</u> Tier 5 | Not Covered | \$0/ retail Rx or refill at specialty pharmacy; <u>deductible</u> does not apply | 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) | No Charge | 50% <u>coinsurance</u> | Not Covered | None |
| | Physician/surgeon fees | No Charge | \$110/visit; <u>deductible</u> does not apply | Not Covered | None |
| If you need immediate medical attention | <u>Emergency room care</u> | No Charge | \$500/visit | \$500/visit | <u>Copayment</u> waived if admitted inpatient within 24 hours |
| | <u>Emergency medical transportation</u> | No Charge | \$350/transport; <u>deductible</u> does not apply | \$350/transport | None |
| | <u>Urgent care</u> | No Charge | \$80/visit | \$80/visit | Services provided by an Out-of- |

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| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| | | | | | 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) | No Charge | 50% coinsurance | Not Covered | Preauthorization is required. |
| | Physician/surgeon fees | No Charge | \$110/visit; deductible does not apply | Not Covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No Charge | \$55/visit; deductible does not apply | Not Covered | |
| | Inpatient services | No Charge | 50% coinsurance | Not Covered | Preauthorization is required. |
| If you are pregnant | Office visits | No Charge | 50% coinsurance | Not Covered | Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC. |
| | Childbirth/delivery professional services | No Charge | \$110/visit; deductible does not apply | Not Covered | None |
| | Childbirth/delivery facility services | No Charge | 50% coinsurance | Not Covered | Preauthorization is required. |
| If you need help recovering or have other special health needs | Home health care | No Charge | 50% coinsurance | Not Covered | Limited to 60 visits per benefit year. Preauthorization is required. |
| | Rehabilitation services | No Charge | 50% coinsurance | Not Covered | Limited to 20 visits each per benefit year for Physical, Occupational, Speech and Pulmonary Therapy. Cardiac Rehab is limited to 36 visits |

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| | | | | | per benefit year. Preauthorization is required. |
| | Habilitation services | No Charge | 50% coinsurance | Not Covered | Limited to 20 visits each per benefit year for Physical, Occupation and Speech Therapy |
| | Skilled nursing care | No Charge | 50% coinsurance | Not Covered | Limited to 30 days per benefit year. Preauthorization is required. |
| | Durable medical equipment | No Charge | 50% coinsurance | Not Covered | Limited to 20 DME devices/items per year, whether rented or purchased as indicated in the Policy. Preauthorization is required. |
| | Hospice services | No Charge | No Charge | Not Covered | Preauthorization is required. |
| If your child needs dental or eye care | Children's eye exam | No Charge | No Charge | Not Covered | Limited to one Routine Eye Exam per 12 month period |
| | Children's glasses | No Charge | No Charge | Not Covered | None |
| | Children's dental check-up | No Charge | No Charge | Not Covered | No Charge via 100% reimbursement for 2 exams, 2 cleanings and one bitewing x-ray per 12 month period |

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
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the United States
- Oral Surgery
- Private-duty nursing
- 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
- 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, 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 1-855-275-1400 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 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 1-855-275-1400 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 plan's overall deductible | \$7,750 |
| ■ Specialist copayment | \$110 |
| ■ Hospital (facility) coinsurance | 50% |
| ■ Other copayment | \$55 |

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 | \$7,750 |
| Copayments | \$0 |
| Coinsurance | \$1,800 |

What isn't covered

| | |
|-----------------------------------|----------------|
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$9,560 |

Managing Joe's Type 2 Diabetes

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$7,750 |
| ■ Specialist copayment | \$110 |
| ■ Hospital (facility) coinsurance | 50% |
| ■ Other copayment | \$55 |

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 | \$800 |
| Copayments | \$800 |
| Coinsurance | \$0 |

What isn't covered

| | |
|-----------------------------------|----------------|
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,620 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$7,750 |
| ■ Specialist copayment | \$110 |
| ■ Hospital (facility) copayment | \$500 |
| ■ Other copayment | \$55 |

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 | \$700 |
| Copayments | \$800 |
| Coinsurance | \$0 |

What isn't covered

| | |
|-----------------------------------|----------------|
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,500 |

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