



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:
<u>What is the overall deductible?</u>	\$1,750 member / \$3,500 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<u>Are there services covered before you meet your deductible?</u>	Yes. Certain <u>preventive services</u> , office visits, tests and prescription drugs are covered before you meet your <u>deductible</u> . See the specific services listed below denoted 'Deductible does not apply'.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	\$8,950 member / \$17,900 family	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> has been met.
<u>What is not included in the out-of-pocket limit?</u>	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 <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. See www.networkhealth.com or call Network Health Customer	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>Out-of-network</u> 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	\$20/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	\$60/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	\$25/visit for lab; deductible does not apply \$50/visit for x-ray; deductible does not apply	Not Covered	Full coverage if required by federal law.
	Imaging (CT/PET scans, MRIs)	No Charge	20% 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)	\$15/retail Rx or refill or \$40/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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		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)	
available at www.networkhealth.com	Preferred brand drugs Tier 2	No Charge (retail or mail order Rx or refill)	\$60/retail Rx or refill or \$165/mail order Rx or refill ; <u>deductible</u> does not apply	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	20% <u>coinsurance</u>	Not Covered	None
	Physician/surgeon fees	No Charge	\$60/visit; <u>deductible</u> does not apply	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	No Charge	\$350/visit; <u>deductible</u> does not apply	\$350/visit; <u>deductible</u> does not apply	<u>Copayment</u> waived if admitted inpatient within 24 hours
	<u>Emergency medical transportation</u>	No Charge	\$175/transport; <u>deductible</u> does not apply	\$175/transport	None

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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)	
	<u>Urgent care</u>	No Charge	\$60/visit; <u>deductible</u> does not apply	\$60/visit; <u>deductible</u> does not apply	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)	No Charge	20% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> is required.
	Physician/surgeon fees	No Charge	\$60/visit; <u>deductible</u> does not apply	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	\$20/visit; <u>deductible</u> does not apply	Not Covered	
	Inpatient services	No Charge	20% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	No Charge	20% <u>coinsurance</u>	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	No Charge	\$60/visit; <u>deductible</u> does not apply	Not Covered	None
	Childbirth/delivery facility services	No Charge	20% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> is required.
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge	20% <u>coinsurance</u>	Not Covered	Limited to 60 visits per benefit year. <u>Preauthorization</u> is required.
	<u>Rehabilitation services</u>	No Charge	20% <u>coinsurance</u>	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	20% coinsurance	Not Covered	Limited to 20 visits each per benefit year for Physical, Occupation and Speech Therapy
	Skilled nursing care	No Charge	20% coinsurance	Not Covered	Limited to 30 days per benefit year. Preauthorization is required.
	Durable medical equipment	No Charge	20% 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	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
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the United States
- 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 1-855-275-1400 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	\$1,750
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	20%
■ Other copayment	\$25

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	\$1,750
Copayments	\$10
Coinsurance	\$1,900

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$3,720

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,750
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	20%
■ Other copayment	\$25

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	\$400
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$1,220

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,750
■ Specialist copayment	\$60
■ Hospital (facility) copayment	\$350
■ Other copayment	\$25

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	\$400
Copayments	\$900
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$1,300

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