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?	$1,500 member / $3,000 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. 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?	$2,300 member / $4,600 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

Important Questions	Answers	Why This Matters:
	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
		Network Provider (You will pay the least)	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	$25/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	$65/visit; deductible does not apply	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)	$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)	20% coinsurance	Not Covered	Preauthorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.networkhealth.com	Generic drugs Tier 1	$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)
	Preferred brand drugs Tier 2	$55/retail Rx or refill or $150/mail order Rx or	Not Covered	Covers up to a 30-day supply (retail prescription); 30-90 day supply (mail

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out of-Network Provider (You will pay the most)	
		refill ; deductible does not apply		order prescription)
	Non-preferred brand drugs Tier 3	50% coinsurance retail Rx or refill or 50% coinsurance mail order Rx or refill	Not Covered	Covers up to a 30-day supply (retail prescription); 30-90 day supply (mail order prescription)
	Preferred Specialty drugs Tier 4	40% coinsurance retail Rx or refill at specialty pharmacy	Not Covered	Covers up to a 30-day supply (specialty pharmacy); No mail order
	Non-Preferred Specialty drugs Tier 5	50% coinsurance retail Rx or refill at specialty pharmacy	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)	20% coinsurance	Not Covered	None
	Physician/surgeon fees	$65/visit; deductible does not apply	Not Covered	None
If you need immediate medical attention	Emergency room care	$350/visit	$350/visit	Copayment waived if admitted inpatient within 24 hours
	Emergency medical transportation	$250/transport; deductible does not apply	$250/transport; deductible does not apply	None
	Urgent care	$80/visit; deductible does not apply	$80/visit; deductible 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)	20% coinsurance	Not Covered	Preauthorization is required.
	Physician/surgeon fees	$65/visit; deductible	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out of-Network Provider (You will pay the most)	
		does not apply		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25/visit; deductible does not apply	Not Covered	
	Inpatient services	20% coinsurance	Not Covered	Preauthorization is required.
If you are pregnant	Office visits	20% 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	$65/visit; deductible does not apply	Not Covered	None
	Childbirth/delivery facility services	20% coinsurance	Not Covered	Preauthorization is required.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	Limited to 60 visits per benefit year. Preauthorization is required.
	Rehabilitation services	20% 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 per benefit year. Preauthorization is required.
	Habilitation services	20% coinsurance	Not Covered	Limited to 20 visits each per benefit year for Physical, Occupation and Speech Therapy
	Skilled nursing care	20% coinsurance	Not Covered	Limited to 30 days per benefit year. Preauthorization is required.
	Durable medical equipment	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	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	None
	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
- 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.

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	$1,500
Specialist copayment	$65
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	$1,500
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,360**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	$1,500
Specialist copayment	$65
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	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

Mia's Simple Fracture

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

The plan's overall deductible	$1,500
Specialist copayment	$65
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	$700
Copayments	$600
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.