**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://assets.networkhealth.com/plandocuments/2027_Individual_Policy.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?** | $0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | 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?** | Yes. Prescription Drugs Tiers 3, 4 and 5 $1,500 member/ $3,000 family. There are no other specific deductibles. | You don't have to meet deductibles for specific services. You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | $12,000 member / $24,000 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 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 |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| | | 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 | $45/visit | Not Covered | None |
| | Specialist visit | $150/visit | 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) | $75/visit for lab<br>$150/visit for x-ray | Not Covered | Full coverage if required by federal law. |
| | Imaging (CT/PET scans, MRIs) | $500/visit | 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 | $30/retail prescription or $75/mail order prescription; 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.<br><br>Retail: Up to a 30-day supply.<br>Mail Order: Up to a 90-day supply.<br><br>Specialty drugs limited to a 30-day supply at a specialty pharmacy. |
| | Preferred brand drugs Tier 2 | $160/retail prescription or $400/mail order prescription; deductible does not apply | Not Covered | |
| | Non-preferred brand drugs Tier 3 | 50% coinsurance retail prescription or 50% coinsurance mail order prescription | Not Covered | |
| | Preferred Specialty drugs Tier 4 | 40% coinsurance retail prescription at specialty | Not Covered | |

| 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) | |
| | | pharmacy | | |
| | Non-Preferred Specialty drugs Tier 5 | 50% coinsurance retail prescription at specialty pharmacy | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $150/visit | Not Covered | None |
| | Physician/surgeon fees | $150/visit | Not Covered | None |
| **If you need immediate medical attention** | Emergency room care | $2,500/visit | $2,500/visit | Copayment waived if admitted inpatient within 24 hours. |
| | Emergency medical transportation | $150/transport | $150/transport | None |
| | Urgent care | $75/visit | $75/visit | 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) | $1,500/day ,days 1-2 | Not Covered | Preauthorization is required. |
| | Physician/surgeon fees | $150/visit | 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) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $45/visit | Not Covered | None |
| | Inpatient services | $1,500/day ,days 1-2 | Not Covered | Preauthorization is required. |
| **If you are pregnant** | Office visits | No Charge | 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 | $150/visit | Not Covered | |
| | Childbirth/delivery facility services | $1,500/day ,days 1-2 | Not Covered | |
| **If you need help recovering or have other special health needs** | Home health care | No Charge | Not Covered | Limited to 60 visits per benefit year. |
| | Rehabilitation services | $75/visit | Not Covered | Preauthorization is required. Limited to 20 visits each per benefit year for Physical, Occupational, Speech and Pulmonary Rehabilitation therapy. |
| | Habilitation services | $75/visit | Not Covered | Preauthorization is required. Limited to 20 visits each per benefit year for Physical, Occupational and Speech Therapy. |
| | Skilled nursing care | $1,500/day ,days 1-5 | Not Covered | Preauthorization is required. Limited to 30 days per confinement. |
| | Durable medical equipment | $150/visit | Not Covered | Preauthorization is required. |
| | Hospice services | No Charge; deductible does not apply | Not Covered | None. |
| **If your child needs dental or eye care** | Children's eye exam | No Charge; deductible does not apply | Not Covered | Limited to one routine exam per 12 month period. |
| | Children's glasses | No Charge; deductible does not apply | Not Covered | None |
| | Children's dental check-up | No Charge; deductible does not apply | Not Covered | No Charge via 100% reimbursement for 2 oral exams, 2 cleanings, 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<br>• Acupuncture<br>• Bariatric surgery<br>• Cosmetic Surgery | • Infertility Treatment<br>• Long-term care<br>• Non-emergency care when traveling outside the United States<br>• Oral Surgery | • Private-duty nursing<br>• Routine foot care<br>• 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<br>• 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 | $0 |
| Specialist copayment | $150 |
| Hospital (facility) | |
| 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)*

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $1,900 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,960** |

## 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) | |
| 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))*

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $1,600 |
| 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 | $0 |
| Specialist copayment | $150 |
| Hospital (facility) copayment | $2,500 |
| 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)*

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $1,300 |
| 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.