SOLO HEALTH

2026 PLAN BRIEF

Plan Provisions, Benefits & Member Procedures

A condensed reference to the Solo Health plan's eligibility rules, schedule of benefits, prior authorization requirements, exclusions, and claims procedures. The complete Summary Plan Description is the controlling document and is available upon request.

solo.health

2026 Plan Year

ABOUT THIS DOCUMENT

How to use this Plan Brief

This Plan Brief summarizes the material provisions of the Solo Health plan for the 2026 plan year. It condenses the plan's eligibility requirements, schedule of benefits, benefit limits, prior authorization requirements, exclusions, and claims and appeals procedures into a single working reference for members and prospective members.

This Brief is a summary. It does not amend, extend, or replace the Summary Plan Description (SPD). In the event of any conflict between this Brief and the SPD, **the SPD controls in all cases**. The full SPD is provided to every member at enrollment as part of the plan document set, is available in the member portal, and may be requested at any time from Solo Support at support@hbgnow.com or 646-328-6968.

Certain provisions of the SPD apply to the Plan Sponsor, the captive structure, or third-party administrators rather than to individual members — including plan funding, administration, coordination of benefits, and recovery provisions. Those provisions are summarized here only to the extent they affect a member directly; the SPD contains them in full.

CONTENTS

01 Plan structure

02 Eligibility & dependents

03 Deductibles & out-of-pocket maximums

04 Schedule of benefits

05 Prior authorization

06 Prescription drug benefits

07 Provider network & out-of-network services

08 Exclusions overview

09 Claims submission & timely filing

10 Appeals

11 Accuracy of information & rescission

12 Contacts & requesting the full SPD

SECTION 01

Plan structure

The Solo Health plan is a self-funded major medical health plan administered by Vault Admin Services, LLC as Third-Party Administrator. Claims above the member's deductible are reimbursed under a Medical Deductible Reimbursement Policy issued by Vault Health Captive, LLC – Series C, a regulated captive domiciled in North Carolina, with reinsurance in place for large claims. The plan's structure and administration are intended to align with the spirit and intent of Title I of ERISA.

Members are never personally responsible for covered claims beyond their deductible. There are no annual or lifetime benefit limits under the plan.

SECTION 02

Eligibility & dependents

The plan is available to self-employed business owners with an active federal Tax ID (EIN) — LLC, S-Corp, or sole proprietor — who complete and pass the plan's health questionnaire. Every individual to be covered under the plan, including dependents, completes a questionnaire. Final eligibility is subject to questionnaire review and approval.

Eligible dependents

- **Legal spouse.** A common-law spouse, civil-union partner, or domestic partner is not an eligible dependent, even where recognized by the state of residence. Documentation of marital status may be required.
- **Dependent children until their 26th birthday** — including natural children, stepchildren, legally adopted children or children placed for adoption, children under court-ordered legal guardianship, and alternate recipients under a Qualified Medical Child Support Order.
- **Totally disabled dependent children** may continue coverage beyond age 26 where the disability began while covered, the child cannot hold self-sustaining employment, the child depends on the member for more than half of their support, and written proof is submitted within 30 days of the date coverage would otherwise end. The plan may request ongoing proof of disability.

Not eligible as dependents

Foster children, grandchildren, domestic partners and their children, and any individual not expressly covered by the plan. No individual may be covered as both a member and a dependent. The plan reserves the right to verify a dependent's eligibility status at any time, and members are obligated to report status changes.

SECTION 03

Deductibles & out-of-pocket maximums

Plan design	Individual deductible / OOP max	Family aggregate / OOP max	HSA-eligible
Standard V2500	$2,500	$5,000	Yes
Standard V5000	$5,000	$10,000	Yes
Standard V10000	$10,000	$20,000	No

The deductible equals the annual out-of-pocket maximum: the plan has no coinsurance, and once the applicable deductible is satisfied, the plan pays 100% of covered medical expenses for the remainder of the plan year. Prescription copays apply after the deductible as set out in Section 06.

Embedded deductibles. Under family coverage, any combination of covered family members may satisfy the family aggregate, but no individual will ever pay more than their own individual deductible. Deductible amounts incurred at any benefit level — in-network or out-of-network — apply toward the deductible. A new deductible applies each plan year.

Amounts that do not count toward the out-of-pocket maximum

- Expenses for excluded services and charges above plan-recognized amounts or applicable limits;
- Penalties, including penalties for failure to obtain required prior authorization;
- Provider-charged legal fees or interest, monthly contributions, and COBRA payments;
- Pharmacy ancillary fees for brand-name medication when a generic is available.

> **No fee forgiveness.** Members are required to pay their out-of-pocket amounts under the plan's terms. If a provider waives or "forgives" a member's deductible or out-of-pocket responsibility, the claim may be denied and the member may become responsible for the entire charge. Such arrangements may also affect HSA eligibility.

SECTION 04

Schedule of benefits

All benefits below are subject to the deductible, plan provisions, medical necessity, and — where marked **PA** — prior authorization. Unless noted, covered services are paid at 100% after the deductible.

Benefit	Plan pays	Limits & notes
Preventive & routine care (exams, screenings, immunizations, well-child, well-woman, mammograms, colonoscopies, FDA-approved contraceptive methods)	100%, deductible waived	Age- and gender-appropriate per ACA guidelines. Breast pumps: one per delivery, up to $150.
Physician services (primary, specialist, OB-GYN, pediatric, in-office services)	100% after deductible	Injections require PA.
Telehealth visits	100%	Not subject to the deductible.
Urgent care, retail clinics, emergency room & emergency physicians	100% after deductible	Emergency services are never subject to network status.
Ambulance — ground & air	100% after deductible	Air ambulance limited to $15,000 per flight. PA required for non-emergency inter-facility transport only.
Inpatient admissions & inpatient surgery (PA)	100% after deductible	Includes inpatient physician charges, anesthesia, inpatient diagnostics.
Outpatient services & outpatient surgery (PA for facility surgery)	100% after deductible	
Maternity — prenatal, delivery, postnatal	100% after deductible	
Mental health & substance use — therapy services	100% after deductible	40 visits per calendar year.
Mental health & substance use — inpatient, residential, outpatient / partial hospitalization (PA)	100% after deductible	
Imaging & diagnostics; advanced imaging (CT, PET, MRI) (PA for advanced imaging)	100% after deductible	
Chiropractic care	100% after deductible	40 visits per calendar year.

Benefit	Plan pays	Limits & notes
Physical therapy & outpatient habilitative services	100% after deductible	40 visits per calendar year each.
Home health care (PA)	100% after deductible	40 visits per calendar year.
Skilled nursing & extended care facilities (PA)	100% after deductible	
Hospice (PA)	100% after deductible	One benefit period, up to 6 months. Bereavement counseling: immediate family, up to 3 visits.
Chemotherapy, radiation, dialysis, sleep studies (PA)	100% after deductible	
Durable medical equipment & prosthetics (PA)	100% after deductible	Prosthetics: $5,000 lifetime maximum. Custom molded foot orthotics: one pair.
Heart, spine, cancer, transplant, knee & hip replacement	100%	Provided through Vault Cares Network Centers of Excellence unless an exception is granted. Includes travel, lodging, and per-diem food benefit for the member plus one companion.

SECTION 05

Prior authorization

Prior authorization is the process of obtaining plan approval before certain elective inpatient admissions, procedures, and services. It confirms that the requested service meets the plan's clinical criteria for coverage. Requests must be received by Vault Admin Services **before** the service or procedure is performed.

Failure to obtain a required prior authorization may result in significant penalties, up to and including non-coverage of the service. Prior authorization is not required for urgent or emergency care, though notification may be required after the patient is stabilized. A granted prior authorization confirms the service meets clinical criteria; all plan terms still apply when the claim is processed.

Services requiring prior authorization are marked **PA** in the Schedule of Benefits and include, among others: inpatient admissions and surgeries, outpatient facility surgery, inpatient and outpatient mental health and substance use treatment, advanced imaging, home health, skilled nursing, hospice, chemotherapy and radiation, dialysis, durable medical equipment, and organ transplants. Vault Admin Services coordinates prior authorization at no cost to the member: 888-211-5706.

SECTION 06

Prescription drug benefits

Prescription benefits are administered by FairosRx. Only medications on the Solo Rx Formulary are covered. Members are responsible for prescription costs until the deductible is met, except Tier 1 preventive medications, which are covered in full with the deductible waived.

Tier	Retail (30-day)	Mail order (90-day)
Tier 1 — ACA Preventive	$0, deductible waived	$0, deductible waived
Tier 2 — Preferred Generics	$15 copay	$30 copay
Tier 3 — Non-Preferred Generics / Preferred Brands	$50 copay	$100 copay
Tier 4 — Non-Preferred Brands	$100 copay	$200 copay
Tier 5 — Specialty	Covered up to $1,000 per prescription	
Tier 6 — Non-Formulary & excluded drugs	Not covered	

- Tier 2–4 copays apply after the deductible is met.
- Non-specialty medications exceeding $1,000 per 30-day supply or $3,000 per 90-day supply are excluded.
- New drugs and dosage forms may not be covered until reviewed and assigned a tier by the Formulary Management Committee.
- Formulary changes are communicated 30 days in advance. An exceptions process is available where a listed agent is not medically appropriate.

SECTION 07

Provider network & out-of-network services

The plan's primary network is MultiPlan PHCS, a Claritev network, a nationwide PPO network with providers in all 50 states. No referrals are required, and members are not restricted to a local service area. Providers can be located at providersearch.multiplan.com.

Out-of-network services are covered subject to the plan's reference-based pricing and usual-and-customary provisions, under which the plan determines the allowable amount for a service. Amounts a provider charges above the plan's allowable amount are handled under the plan's pricing and provider-resolution provisions; balance-billing support is available through the plan's advocacy partners. Members should not pay out-of-pocket upfront for out-of-network services when possible, and should allow providers to bill Vault Admin Services directly. The full methodology by which allowable amounts are determined is set out in the SPD.

Emergency services are always treated as in-network, without prior authorization, at the nearest facility able to provide care.

SECTION 08

Exclusions overview

The plan maintains a comprehensive list of general exclusions in the SPD, which governs all exclusion determinations. Complications arising from excluded services are also excluded. Categories of excluded services include, but are not limited to:

- **Cosmetic and elective:** cosmetic treatment and surgery, abdominoplasty, and related procedures, unless otherwise listed as covered;
- **Alternative and unproven care:** acupuncture, holistic and homeopathic treatment, biofeedback, experimental or investigational treatments, and cell and gene therapy;
- **Reproductive and weight-related:** infertility treatment and surrogacy-related services, bariatric surgery, and weight-loss programs;
- **Dental, vision, and related:** dental and vision care (except as expressly covered, e.g., accidental injury; optional dental and vision plans are available separately), vision therapy, and TMJ treatment;
- **Long-term and custodial:** long-term care and assistance with activities of daily living;
- **Other:** work-related injuries, services before enrollment or after termination, missed appointments, expenses payable under automobile coverage, charges exceeding plan-recognized amounts, and claims received later than 12 months from the date of service.

This overview is categorical and intentionally summarized. Members and providers should consult the SPD's General Exclusions section, or contact Vault Admin Services, before assuming any specific service is covered or excluded.

SECTION 09

Claims submission & timely filing

Most providers bill the plan directly, and members have no claim to file. Solo is an open-access plan: any provider willing to submit claims to Vault Admin Services may be used. Where a provider will not bill the plan directly, the member may self-submit:

- Submit the claim through the Solo Member Portal claims tool (log in at solo.health, or the partner domain where you set up your plan, then go to your account → Claims);
- Attach itemized bills including patient information, provider name, address and tax ID, date of service, ICD-10 diagnosis codes, CPT procedure codes, and total charge;
- For assistance with a submission, contact Vault Admin Services at 888-211-5706.

> **Timely filing:** claims received later than **12 months from the date of service** are excluded from coverage and will be denied.

A member or provider may optionally request a pre-determination — a non-binding advance indication of whether a service is generally covered. A pre-determination is not a claim, cannot be appealed, and does not guarantee payment; all plan terms apply when the claim is submitted.

SECTION 10

Appeals

A member who disagrees with an adverse benefit determination may appeal. The plan provides three levels of review:

Level	Review	Filing deadline
Level I	Internal appeal	Within 180 days of the initial denial
Level II	External review	Within 4 months of the Level I determination
Level III	Arbitration	Within 60 days of the Level II determination

All appeals are submitted in writing to Vault Admin Services, Attention: Appeals, 4022 E. Greenway, Ste. 11-12, Phoenix, AZ 85022 · 877-424-2366. The SPD sets out the complete appeal procedures, required contents, and determination timelines.

SECTION 11

Accuracy of information & rescission

Members are responsible for providing accurate and truthful information — including on the health questionnaire and regarding family status and dependent eligibility — and for updating previously provided information when circumstances change. Coverage may be retroactively canceled (rescinded) where a member acts fraudulently or intentionally makes a material misrepresentation of fact, with 30 days' advance notice as required by law. A rescission determination is itself appealable as an adverse benefit determination.

SECTION 12

Contacts & requesting the full SPD

Contact	Handles	Reach
Solo Support (HBG)	Enrollment, general member support, SPD requests	646-328-6968 · support@hbgnow.com · M–F 9am–5pm ET
Vault Admin Services	Claims, EOBs, deductible tracking, prior authorization, appeals	888-211-5706 · claims@allthingsvault.com · M–F 8am–5pm CT
FairosRx	Pharmacy benefits, formulary, copays	833-464-9600 · ContactUs@FairosRx.com
MultiPlan PHCS (Claritev)	Provider search	providersearch.multiplan.com
Clever Health	Virtual urgent care, primary care, mental health	cleverhealth.ai/contact

Requesting the full Summary Plan Description

The complete 2026 SPD is provided to every member at enrollment as part of the signed plan document set and is available in the member portal. Members and prospective members may request a copy at any time from Solo Support at support@hbgnow.com or 646-328-6968.

This Plan Brief is a summary prepared for the convenience of members and prospective members and is not a contract. The governing document for all coverage terms, conditions, limits, exclusions, and procedures is the official 2026 Summary Plan Description; in any conflict, the SPD controls. Solo Health is a self-funded health plan offered through Solo Health Collective in participation with Vault Health Captive, LLC – Series C, a regulated captive domiciled in North Carolina. Nothing in this Brief guarantees coverage or payment of any specific claim; determinations depend on plan administration, medical necessity, prior authorization, and the terms of the SPD. · solo.health · 2026 Plan Year