



PRESTIGE_2026_BRONZE_0_MEDICAL_DEDUCTIBLE_NA_NC

Coverage for: Individual or Individual+Family | Plan Type:

IFP_HMO_ACA



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 ?	\$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 ?	All services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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 ?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit ?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
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 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 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	No Charge	Not Covered	None
	Specialist visit	No Charge	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)	No Charge	Not Covered	Full coverage if required by federal law.
	Imaging (CT/PET scans, MRIs)	No Charge	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	No Charge/retail Rx or refill/no mail order	Not Covered	Covers up to a 30-day supply (retail prescription)
	Preferred brand drugs Tier 2	No Charge/retail Rx or refill/no mail order	Not Covered	Covers up to a 30-day supply (retail prescription)
	Non-preferred brand drugs Tier 3	No Charge/retail Rx or refill/no mail order	Not Covered	Covers up to a 30-day supply (retail prescription)
	Preferred Specialty drugs Tier 4	No Charge/retail Rx or refill/no mail order	Not Covered	Covers up to a 30-day supply (specialty pharmacy)
	Non-Preferred Specialty drugs Tier 5	No Charge/retail Rx or refill/no mail order	Not Covered	Covers up to a 30-day supply (specialty pharmacy)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room care	No Charge	No Charge	
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	No Charge	No Charge	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider Provider (You will pay the least)	Out of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Preauthorization is required.
	Physician/surgeon fees	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	Not Covered	None
	Inpatient services	No Charge	Not Covered	Preauthorization is required.
If you are pregnant	Office visits	No Charge	Not Covered	None
	Childbirth/delivery professional services	No Charge	Not Covered	None
	Childbirth/delivery facility services	No Charge	Not Covered	Preauthorization is required.
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. Preauthorization is required.
	Rehabilitation services	No Charge	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	No Charge	Not Covered	Limited to 20 visits each per benefit year for Physical, Occupation and Speech Therapy
	Skilled nursing care	No Charge	Not Covered	Limited to 30 days per benefit year. Preauthorization is required.
	Durable medical equipment	No Charge	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	No Charge	Not Covered	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.

number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.02** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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	\$0
■ Hospital (facility)	\$0
■ Other	\$0

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:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$60

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	\$0
■ Hospital (facility)	\$0
■ Other	\$0

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:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$20

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist	\$0
■ Hospital (facility)	\$0
■ Other	\$0

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:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$0

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