



## HMO COCHOICE PLAN SUMMARY OF MEMBER RESPONSIBILITY TABLE

**This Summary reflects your member copayments and other out-of-pocket expenses.**

Out-of-pocket expenses incurred to satisfy deductible and coinsurance, apply toward the out-of-pocket limit when the services are provided by a Network Health Plan participating provider.

The following will not apply toward the out-of-pocket limit: copayments, non-covered services and denied benefits when prior authorization is not obtained.

### **IN NETWORK:**

<b>Annual Deductible:</b>	<b>\$750 per Member and \$1,500 per Family each Benefit year</b>
<b>Member's Coinsurance:</b>	<b>20% of Eligible Expenses, unless otherwise specified</b>
<b>Out-of-Pocket Limit:</b>	<b>\$2,750 per Member and \$5,500 per Family each Benefit year</b>

This is a summary of your health care coverage.

All benefits are subject to the terms, limitations and exclusions of the Certificate of Coverage. Please refer to your Certificate of Coverage, Preventive Coverage or Preventive Services Guide and any applicable Riders for detailed benefits information, eligible services and coverage guidelines. Network Health Plan's coverage includes benefits for all State of Wisconsin and Federal mandated benefits.

Please contact Network Health Plan's Customer Service Department at 1-800-826-0940 for assistance in understanding your health care benefits.

HMO Plans underwritten by Network Health Plan

<b>Services</b>	<b>Benefits</b>	<b>Member Responsibility</b>
<b>Preventive Health</b>	Please refer to your Member Handbook for a copy of the Preventive Coverage or Preventive Services Guide document, as applicable.	No Charge
<b>Physician and Practitioner Services</b>	Primary Care Practitioner Home & Office Visits	\$30 Copay per visit
	Specialist Home & Office Visits	\$60 Copay per visit
	Routine Vision Exam	No Charge
	Primary Care Practitioner Inpatient Visits	No Charge
	Specialist Inpatient Visits	No Charge
	Allergy desensitization shots, Radiation, Chemotherapy, Dialysis, Surgery & Anesthesiology services and other outpatient services or procedures performed in the Practitioners office not otherwise listed on this table.	Deductible/Coinsurance
	Accidental Dental Services	\$60 Copay per visit
	Maternity Care	No Charge
	Chiropractic Office Visits & Manipulations	\$30 Copay per visit
<b>Infusion Services</b>	Medications administered in the Practitioners office, Outpatient facility, Dialysis facility or in the home	Please refer to your Prescription Drug Rider
<b>Diagnostic Services</b>	X-Ray, Lab, Pathology Practitioners office or outpatient	Deductible/Coinsurance
	Diagnostic Mammography Services Practitioners office or outpatient	Deductible/Coinsurance
	PET Scans, MRIs, MRA's, CT Scans	\$100 Copay/Coinsurance per procedure
	Stress Tests	\$100 Copay/Coinsurance per procedure
	Ultrasounds/ Echocardiograms	\$50 Copay/Coinsurance per procedure
<b>Hospital Services</b>	Inpatient Hospital	Deductible/Coinsurance
	Outpatient Services or Procedures Including Cardiac Rehabilitation	Deductible/Coinsurance
	Ambulatory Surgical Center	Deductible/Coinsurance
<b>Rehabilitation Services</b>	Therapy – Physical/Occupational/Speech	Deductible/Coinsurance
<b>Home Health Care</b>		Deductible/Coinsurance
<b>Hospice Care</b>		Deductible/Coinsurance
<b>Durable Medical Equipment</b>		Deductible/Coinsurance
<b>Medical Supplies</b>	Including insulin pump supplies	Deductible/Coinsurance

Services	Benefits	Member Responsibility
<b>Behavioral Health</b> Mental Health and Chemical Dependency Services	Inpatient Limited to 10 days per Benefit year  Transitional Limited to 20 days per Benefit year  Outpatient Limited to 20 visits per Benefit year	Deductible/Coinsurance  \$60 Copay per visit  \$60 Copay per visit
<b>Ambulance Services</b>	Land and Air	\$100 Copay/Coinsurance per transport
<b>Emergency/Urgent Care</b>	Emergency Room Services (Copay waived if admitted inpatient within 24 hours) Urgent Care	\$200 Copay per visit  \$100 Copay per visit
<b>Health Education Programs</b>	Please refer to Certificate of Coverage for list of benefits & limitations	No Charge
<b>Diabetic Supplies</b>	Please refer to the Prescription Summary of Member Responsibility Table	
<b>Prescription Drugs:</b>	Please see the Prescription Summary of Member Responsibility Table for prescription drug information, including medications administered in the Office or Outpatient setting.	