HMO 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:	
Annual Deductible:	**$2,000 per Member and $6,000 per Family each Benefit year**
Member's Coinsurance:	**20% of Eligible Expenses, unless otherwise specified**
Out-of-Pocket Limit:	**$5,000 per Member and $10,000 per Family each Benefit year**

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.

Services	Benefits	Member Responsibility
Preventive Health	Please refer to your Member Handbook for a copy of the Preventive Coverage or Preventive Services Guide document, as applicable.	No Charge
Physician and Practitioner Services	Primary Care Practitioner Home & Office Visits	$30 Copay per visit
	Specialist Home & Office Visits	$60 Copay per visit
	Routine Vision Exam	$30 Copay per visit
	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.	No Charge
	Accidental Dental Services	No Charge
	Maternity Care	No Charge
	Chiropractic Office Visits & Manipulations	$30 Copay per visit
Infusion Services	Medications administered in the Practitioners office, Outpatient facility, Dialysis facility or in the home	Please refer to your Prescription Drug Rider
Diagnostic Services	X-Ray, Lab, Pathology Practitioners office or outpatient	No Charge
	Diagnostic Mammography Services Practitioners office or outpatient	No Charge
	PET Scans, MRIs, MRA's, CT Scans	No Charge
	Stress Tests	No Charge
	Ultrasounds/ Echocardiograms	No Charge
Hospital Services	Inpatient Hospital	Deductible/Coinsurance
	Outpatient Services or Procedures Including Cardiac Rehabilitation	Deductible/Coinsurance
	Ambulatory Surgical Center	Deductible/Coinsurance
Rehabilitation Services	Therapy – Physical/Occupational/Speech	$30 Copay per visit
Home Health Care		No Charge
Hospice Care		No Charge
Durable Medical Equipment		Deductible/Coinsurance
Medical Supplies	Including insulin pump supplies	No Charge

Services	Benefits	Member Responsibility
Behavioral Health 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
Ambulance Services	Land and Air	Deductible/Coinsurance
Emergency/Urgent Care	Emergency Room Services (Copay waived if admitted inpatient within 24 hours) Urgent Care	$200 Copay per visit $100 Copay per visit
Health Education Programs	Please refer to Certificate of Coverage for list of benefits & limitations	No Charge
Diabetic Supplies	Please refer to the Prescription Summary of Member Responsibility Table	
Prescription Drugs:	Please see the Prescription Summary of Member Responsibility Table for prescription drug information, including medications administered in the Office or Outpatient setting.	