



HSA HMO PLAN
SUMMARY OF MEMBER RESPONSIBILITY TABLE
“A Health Savings Account Qualified Plan”

**This Summary reflects your member out-of-pocket expenses.
For Family coverage, benefits are not paid for any one Family member, until the entire Family deductible is met.**

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. Non-covered services and benefits denied when prior authorization is not obtained, will not apply toward the out-of-pocket limit.

IN NETWORK:

| | |
|------------------------------|--|
| Annual Deductible: | \$2,000 Self only coverage and \$4,000 Family each Benefit year |
| Member’s Coinsurance: | 20% of Eligible Expenses, unless otherwise specified |
| Out-of-Pocket Limit: | \$3,000 Self only coverage and \$6,000 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 | Deductible/Coinsurance |
| | Specialist Home & Office Visits | Deductible/Coinsurance |
| | Routine Vision Exam | Deductible/Coinsurance |
| | Primary Care Practitioner Inpatient Visits | Deductible/Coinsurance |
| | Specialist Inpatient Visits | Deductible/Coinsurance |
| | 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 | Deductible/Coinsurance |
| | Maternity Care | Deductible/Coinsurance |
| | Chiropractic Office Visits & Manipulations | Deductible/Coinsurance |
| 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 | Deductible/Coinsurance |
| | Diagnostic Mammography Services Practitioners office or outpatient | Deductible/Coinsurance |
| | PET Scans, MRIs, MRA's, CT Scans | Deductible/Coinsurance |
| | Stress Tests | Deductible/Coinsurance |
| | Ultrasounds/ Echocardiograms | Deductible/Coinsurance |
| 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 | Deductible/Coinsurance |
| Home Health Care | | Deductible/Coinsurance |
| Hospice Care | | Deductible/Coinsurance |
| Durable Medical Equipment | | Deductible/Coinsurance |
| Medical Supplies | Including insulin pump supplies | Deductible/Coinsurance |

| 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 Deductible/Coinsurance Deductible/Coinsurance |
| Ambulance Services | Land and Air | Deductible/Coinsurance |
| Emergency/Urgent Care | Emergency Room Services Urgent Care | Deductible/Coinsurance Deductible/Coinsurance |
| 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. | |