



**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 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:** \$2,500 Self only coverage and \$5,000 Family each Benefit year

**Member’s Coinsurance:** 0% of Eligible Expenses, unless otherwise specified

**Out-of-Pocket Limit:** \$2,500 Self only coverage and \$5,000 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.

<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	Deductible
	Specialist Home & Office Visits	Deductible
	Routine Vision Exam	Deductible
	Primary Care Practitioner Inpatient Visits	Deductible
	Specialist Inpatient Visits	Deductible
	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
	Accidental Dental Services	Deductible
	Maternity Care	Deductible
	Chiropractic Office Visits & Manipulations	Deductible
<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
	Diagnostic Mammography Services Practitioners office or outpatient	Deductible
	PET Scans, MRIs, MRA's, CT Scans	Deductible
	Stress Tests	Deductible
	Ultrasounds/ Echocardiograms	Deductible
<b>Hospital Services</b>	Inpatient Hospital	Deductible
	Outpatient Services or Procedures Including Cardiac Rehabilitation	Deductible
	Ambulatory Surgical Center	Deductible
<b>Rehabilitation Services</b>	Therapy – Physical/Occupational/Speech	Deductible
<b>Home Health Care</b>		Deductible
<b>Hospice Care</b>		Deductible
<b>Durable Medical Equipment</b>		Deductible
<b>Medical Supplies</b>	Including insulin pump supplies	Deductible

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   Deductible   Deductible
<b>Ambulance Services</b>	Land and Air	Deductible
<b>Emergency/Urgent Care</b>	Emergency Room Services  Urgent Care	Deductible  Deductible
<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.	