



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:	\$5,000 Self only coverage and \$10,000 Family each Benefit year
Member’s Coinsurance:	0% of Eligible Expenses, unless otherwise specified
Out-of-Pocket Limit:	\$5,000 Self only coverage and \$10,000 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
	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
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
	Diagnostic Mammography Services Practitioners office or outpatient	Deductible
	PET Scans, MRIs, MRA's, CT Scans	Deductible
	Stress Tests	Deductible
	Ultrasounds/ Echocardiograms	Deductible
Hospital Services	Inpatient Hospital	Deductible
	Outpatient Services or Procedures Including Cardiac Rehabilitation	Deductible
	Ambulatory Surgical Center	Deductible
Rehabilitation Services	Therapy – Physical/Occupational/Speech	Deductible
Home Health Care		Deductible
Hospice Care		Deductible
Durable Medical Equipment		Deductible
Medical Supplies	Including insulin pump supplies	Deductible

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