



**HSA POS 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 In-Network out-of-pocket limit when the services are provided by a Network Health Plan Participating Provider.

Out-of-pocket expenses incurred when the services are not provided by a Network Health Plan Participating Provider will apply toward the out-of-network benefits.

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

**IN-NETWORK:**

<b>Annual Deductible:</b>	<b>\$1,500 Self only coverage and \$3,000 Family each Benefit year</b>
<b>Member’s Coinsurance:</b>	<b>0% of Eligible Expenses, unless otherwise specified</b>
<b>Out-of-Pocket Limit:</b>	<b>\$1,500 Self only coverage and \$3,000 Family each Benefit year</b>

**OUT-OF-NETWORK:**

**Coverage for Out-of-Network services which require Prior Authorization as listed in your Point of Service Plan Rider will have a 10% benefit reduction if the services are not Prior Authorized.**

<b>Annual Deductible:</b>	<b>\$2,500 Self only coverage and \$5,000 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>\$4,500 Self only coverage and \$9,000 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.

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

Services	Benefits	Member Responsibility	
		In-Network	Out-of-Network
<b>Behavioral Health</b> Mental Health & Chemical Dependency Services	Inpatient Limited to 10 days per Benefit year	Deductible	Deductible/Coinsurance
	Transitional Limited to 20 days per Benefit year	Deductible	Deductible/Coinsurance
	Outpatient Limited to 20 visits per Benefit year	Deductible	Deductible/Coinsurance
<b>Ambulance Services</b>	Land and Air	Deductible	
<b>Emergency/Urgent Care</b>	Emergency Room Services	Deductible	
	Urgent Care	Deductible	Deductible/Coinsurance
<b>Health Education Programs</b>	Please refer to the Certificate of Coverage for list of benefits & limitations	No Charge	Not Covered
<b>Diabetic Supplies</b>	Please refer to the Prescription Summary of Member Responsibility Table		
<b>Prescription Drugs:</b>	Please see Prescription Coverage tab for Prescription Drug information, including Drugs administered in the Office or Outpatient setting.		