



**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 and coinsurance, 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>\$4,000 Self only coverage and \$8,000 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>\$5,000 Self only coverage and \$10,000 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>\$5,000 Self only coverage and \$10,000 Family each Benefit year</b>  |
| <b>Member’s Coinsurance:</b> | <b>40% of Eligible Expenses, unless otherwise specified</b>              |
| <b>Out-of-Pocket Limit:</b>  | <b>\$10,000 Self only coverage and \$20,000 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/Coinsurance                       | Deductible/Coinsurance |
|  | Specialist Home & Office Visits   | Deductible/Coinsurance                       | Deductible/Coinsurance |
|  | Routine Vision Exam   | Deductible/Coinsurance                       | Deductible/Coinsurance |
|  | Primary Care Practitioner Inpatient Visits  | Deductible/Coinsurance                       | Deductible/Coinsurance |
|  | Specialist Inpatient Visits   | Deductible/Coinsurance                       | 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                       | Deductible/Coinsurance |
|  | Accidental Dental Services  | Deductible/Coinsurance                       | Deductible/Coinsurance |
|  | Maternity Care  | Deductible/Coinsurance                       | Deductible/Coinsurance |
|  | Chiropractic Office Visits & Manipulations  | Deductible/Coinsurance                       | 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/Coinsurance                       | Deductible/Coinsurance |
|  | Diagnostic Mammography Services Practitioners office or outpatient  | Deductible/Coinsurance                       | Deductible/Coinsurance |
|  | PET Scans, MRIs, MRA's, CT Scans  | Deductible/Coinsurance                       | Deductible/Coinsurance |
|  | Stress Tests  | Deductible/Coinsurance                       | Deductible/Coinsurance |
|  | Ultrasounds/ Echocardiograms  | Deductible/Coinsurance                       | Deductible/Coinsurance |
| <b>Hospital Services</b>                   | Inpatient Hospital  | Deductible/Coinsurance                       | Deductible/Coinsurance |
|  | Outpatient Services or Procedures Including Cardiac Rehabilitation  | Deductible/Coinsurance                       | Deductible/Coinsurance |
|  | Ambulatory Surgical Center  | Deductible/Coinsurance                       | Deductible/Coinsurance |
| <b>Rehabilitation Services</b>             | Therapy – Physical/Occupational/Speech  | Deductible/Coinsurance                       | Deductible/Coinsurance |
| <b>Home Health Care</b>                    |   | Deductible/Coinsurance                       | Deductible/Coinsurance |
| <b>Hospice Care</b>                        |   | Deductible/Coinsurance                       | Deductible/Coinsurance |
| <b>Durable Medical Equipment</b>           |   | Deductible/Coinsurance                       | Deductible/Coinsurance |
| <b>Medical Supplies</b>                    | Including insulin pump supplies   | Deductible/Coinsurance                       | Deductible/Coinsurance |

| Services   | Benefits   | Member Responsibility  |                        |
|--|--|------------------------|------------------------|
|  |  | In-Network             | Out-of-Network         |
| <b>Behavioral Health</b><br>Mental Health &<br>Chemical Dependency<br>Services | Inpatient<br>Limited to 10 days per Benefit year   | Deductible/Coinsurance | Deductible/Coinsurance |
|  | Transitional<br>Limited to 20 days per Benefit year  | Deductible/Coinsurance | Deductible/Coinsurance |
|  | Outpatient<br>Limited to 20 visits per Benefit year  | Deductible/Coinsurance | Deductible/Coinsurance |
| <b>Ambulance Services</b>  | Land and Air   | Deductible/Coinsurance |                        |
| <b>Emergency/Urgent<br/>Care</b>   | Emergency Room Services  | Deductible/Coinsurance |                        |
|  | Urgent Care  | Deductible/Coinsurance | Deductible/Coinsurance |
| <b>Health Education<br/>Programs</b>   | Please refer to the Certificate of<br>Coverage for list of benefits &<br>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<br>in the Office or Outpatient setting. |                        |                        |