



**POS COCHOICE PLAN
SUMMARY OF MEMBER RESPONSIBILITY TABLE**

This Summary reflects your member copayments and other out-of-pocket expenses.

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: copayments, non-covered services, denied benefits, and the benefit reduction amount when prior authorization is not obtained.

IN-NETWORK

Annual Deductible:	\$2,500 per Member and \$5,000 per Family each Benefit year
Member's Coinsurance:	20% of Eligible Expenses, unless otherwise specified
Out-of-Pocket Limit:	\$4,500 per Member and \$9,000 per Family each Benefit year

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.

Annual Deductible:	\$5,000 per Member and \$10,000 per Family each Benefit year
Member's Coinsurance:	40% of Eligible Expenses, unless otherwise specified
Out of Pocket Limit:	\$9,000 per Member and \$18,000 per 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	
		In-Network	Out-of-Network
Preventive Health	Please refer to your Member Handbook for a copy of the Preventive Coverage or Preventive Services Guide document, as applicable.	No Charge	Deductible/Coinsurance
Physician and Practitioner Services	Primary Care Practitioner Home & Office Visits	\$30 Copay per visit	Deductible/Coinsurance
	Specialist Home & Office Visits	\$60 Copay per visit	Deductible/Coinsurance
	Routine Vision Exam	No Charge	Deductible/Coinsurance
	Primary Care Practitioner Inpatient Visits	No Charge	Deductible/Coinsurance
	Specialist Inpatient Visits	No Charge	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	\$60 Copay per visit	\$60 Copay per visit
	Maternity Care	No Charge	Deductible/Coinsurance
Chiropractic Office Visits & Manipulations	\$30 Copay per visit	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	Deductible/Coinsurance
	Diagnostic Mammography Services Practitioners office or outpatient	Deductible/Coinsurance	Deductible/Coinsurance
	PET Scans, MRIs, MRA's, CT Scans	\$100 Copay/Coinsurance per procedure	\$100 Copay/Coinsurance per procedure
	Stress Tests	\$100 Copay/Coinsurance per procedure	\$100 Copay/Coinsurance per procedure
	Ultrasounds/ Echocardiograms	\$50 Copay/Coinsurance per procedure	\$50 Copay/Coinsurance per procedure
Hospital Services	Inpatient Hospital	Deductible/Coinsurance	Deductible/Coinsurance
	Outpatient Services or Procedures Including Cardiac Rehabilitation	Deductible/Coinsurance	Deductible/Coinsurance
	Ambulatory Surgical Center	Deductible/Coinsurance	Deductible/Coinsurance
Rehabilitation Services	Therapy –Physical/Occupational/Speech	Deductible/Coinsurance	Deductible/Coinsurance
Home Health Care		Deductible/Coinsurance	Deductible/Coinsurance
Hospice Care		Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equipment		Deductible/Coinsurance	Deductible/Coinsurance
Medical Supplies	Including insulin pump supplies	Deductible/Coinsurance	Deductible/Coinsurance

Services	Benefits	Member Responsibility	
		In-Network	Out-of-Network
Behavioral Health Mental Health & Chemical Dependency Services	Inpatient Limited to 10 days per Benefit year	Deductible/Coinsurance	Deductible/Coinsurance
	Transitional Limited to 20 days per Benefit year	\$60 Copay per visit	Deductible/Coinsurance
	Outpatient Limited to 20 visits per Benefit year	\$60 Copay per visit	Deductible/Coinsurance
Ambulance Services	Land and Air	\$100 Copay per transport	
Emergency/Urgent Care	Emergency Room Services (Copay waived if admitted inpatient within 24 hours)	\$200 Copay per visit	
	Urgent Care	\$100 Copay per visit	Deductible/Coinsurance
Health Education Programs	Please refer to the Certificate of Coverage for list of benefits & limitations	No Charge	Not Covered
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.		