HMO $20 COPAY 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 out-of-pocket limit when the services are provided by a Network Health Plan participating provider.

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

IN NETWORK:	
Out-of-Pocket Limit:	**$2,000 per Member and $4,000 per Family each Benefit year**

Maximum Policy Benefit:	**$5,000,000 per Member per Lifetime**

This is a summary of your health care coverage.

All benefits are subject to the terms of your policy. Please refer to your Certificate of Coverage and any applicable Riders for detailed benefit information, restrictions, limitations and exclusions that apply to that coverage.

Please contact Network Health Plan's Customer Service Department at 1-800-826-0940 for assistance in understanding your health care benefits.

HMO Plans underwritten by Network Health Plan
POS plans underwritten by Network Health Insurance Corporation and Network Health Plan

Services	Benefits	Member Responsibility
Preventive Health	• Child Preventive Visit	No Charge
	• Adult Preventive Visit	No Charge
	• Immunizations	No Charge
	• Routine Mammography	No Charge
	• Routine Vision Exam	No Charge
Physician and Practitioner Services	• Primary Care Practitioner Home & Office Visits	$20 Copay per visit
	• Specialist Home & Office Visits	$40 Copay per visit
	• Primary Care Practitioner Inpatient Visits	No Charge
	• Specialist Inpatient Visits	No Charge
	• Allergy Immunizations	No Charge
	• Accidental Dental Services	$40 Copay per visit
	• Radiation/Chemotherapy Services	No Charge
	• Dialysis Services	No Charge
	• Surgery & Anesthesiology Services	No Charge
	• Maternity Care	$100 Copay per pregnancy
	• Chiropractic Office Visits & Manipulations	$20 Copay per visit
	• Medications Administered in a Physician's Office	Please refer to your Prescription Drug Rider
Diagnostic Services	• X-Ray, Lab, Pathology Practitioners office or outpatient	No Charge
	• Diagnostic Mammography Services Practitioners office or outpatient	No Charge
	• PET Scans, MRIs, MRA's, CT Scans	$100 Copay per procedure
	• Stress Tests	$100 Copay per procedure
	• Ultrasounds/ Echocardiograms	$50 Copay per procedure
Hospital Services	• Inpatient Hospital	$400 Copay per day up to a maximum of $800 per occurrence
	• Outpatient Services or Procedures Including Cardiac Rehabilitation	$200 Copay per procedure
	• Ambulatory Surgical Center	$200 Copay per procedure
Rehabilitation Services	• Therapy – Physical/Occupational/Speech	$ 20 Copay per visit
Home Health Care		No Charge
Hospice Care		No Charge

Services	Benefits	Member Responsibility
Durable Medical Equipment		No Charge
Medical Supplies	Including insulin pump supplies	No Charge
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	$400 Copay per Inpatient stay $40 Copay per visit $40 Copay per visit
Ambulance Services	• Land and Air	$100 Copay per transport
Emergency/Urgent Care	• Emergency Room Services (Copay waived if admitted inpatient within 24 hours) • Urgent Care	$200 Copay per visit $100 Copay per visit
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.	