



**HMO \$30 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.

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| IN NETWORK: | |
| Out-of-Pocket Limit: | \$3,000 per Member and \$6,000 per Family each Benefit year |

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|--------------------------------|--|
| Maximum Policy Benefit: | \$5,000,000 per Member per Lifetime |
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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.

| 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 | \$30 Copay per visit |
| | • Specialist Home & Office Visits | \$60 Copay per visit |
| | • Primary Care Practitioner Inpatient Visits | No Charge |
| | • Specialist Inpatient Visits | No Charge |
| | • Allergy Immunizations | No Charge |
| | • Accidental Dental Services | \$60 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 | \$30 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 |
| • 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 | \$30 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 | <ul style="list-style-type: none"> • Inpatient Limited to 10 days per Benefit year • Transitional Limited to 20 days per Benefit year • Outpatient Limited to 20 visits per Benefit year | <p style="text-align: center;">\$400 Copay per Inpatient stay</p> <p style="text-align: center;">\$60 Copay per visit</p> <p style="text-align: center;">\$60 Copay per visit</p> |
| Ambulance Services | • Land and Air | \$100 Copay per transport |
| Emergency/Urgent Care | <ul style="list-style-type: none"> • Emergency Room Services (Copay waived if admitted inpatient within 24 hours) • Urgent Care | <p style="text-align: center;">\$200 Copay per visit</p> <p style="text-align: center;">\$100 Copay per visit</p> |
| 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. | |