



**HMO1026  
NETWORK HMO-3 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. Costs of non-covered services, copayments, charges in excess of U&C amount, and benefits reduced when prior authorization is not obtained, will not apply toward the out-of-pocket limit.

<b><u>IN-PLAN:</u></b>	
Annual Deductible:	\$250 per Member and \$500 per Family each year
Member's Coinsurance:	10% of Eligible Expenses, unless otherwise specified
Out-of-Pocket Limit:	\$2,000 per Member and \$4,000 per Family each year

Maximum Policy Benefit:	\$5,000,000 per Member per Lifetime
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**All benefits are subject to the terms, limitations and exclusions of the Policy and Certificate of Coverage. Network Health Plan's coverage includes benefits for all state-mandated benefits. Please refer to your Certificate of Coverage and any applicable Riders for detailed benefit information, eligible services and coverage guidelines.**

This summary describes your health care coverage in general terms. For a completed description of your health care coverage, restrictions, limitations and exclusions that apply to that coverage please contact Network Health Plan's Customer Service Department at 1-800-826-0940 or refer to your policy's Certificate of Coverage.

## NETWORK HEALTH PLAN

Services	Benefits	Member Responsibility
<b>Wellness/Preventive Health</b>	<ul style="list-style-type: none"> <li>• Well Child Care Exams</li> <li>• Periodic Physical Exams</li> <li>• Immunizations</li> <li>• Routine Mammography Services</li> </ul>	<p>No Charge No Charge No Charge No Charge</p>
<b>Physician and Practitioner Services</b>	<p><b>Primary Care Practitioner</b></p> <ul style="list-style-type: none"> <li>• Office and Home visits</li> <li>• Inpatient visits</li> </ul> <p><b>Specialty Physician</b></p> <ul style="list-style-type: none"> <li>• Office and Home visits</li> <li>• Routine Eye Exams <i>(limited to one per 12 month period)</i></li> <li>• Chiropractic office visits and manipulations</li> <li>• Allergy Immunizations</li> <li>• Accidental Dental Services</li> <li>• Radiation/Chemotherapy Services</li> <li>• Dialysis Services</li> <li>• Surgery &amp; Anesthesiology Services</li> <li>• Routine Maternity <i>(pre &amp; post natal care)</i></li> <li>• Inpatient visits</li> <li>• Injectables administered in a Physician's office</li> </ul>	<p>\$20 Copayment per visit No Charge</p> <p>\$20 Copayment per visit \$20 Copayment per visit</p> <p>\$20 Copayment per visit No Charge No Charge No Charge No Charge No Charge No Charge No Charge <i>Please refer to your Prescription drug benefit levels.</i></p>
<b>Diagnostic Services</b>	<ul style="list-style-type: none"> <li>• X-Ray, Lab, Pathology <i>(practitioners office or outpatient)</i></li> <li>• Diagnostic Mammography Services</li> <li>• PET Scans, MRI's, MRA's, CT Scans <i>No coverage if not prior authorized</i></li> <li>• Stress Tests</li> <li>• Ultrasounds/Echocardiograms</li> </ul>	<p>No Charge</p> <p>No Charge</p> <p>No Charge</p> <p>No Charge</p> <p>No Charge</p>
<b>Hospital Services</b>	<ul style="list-style-type: none"> <li>• Inpatient Hospital <i>No Coverage if not prior authorized</i></li> <li>• Outpatient Services or Procedures <i>(Including Cardiac Rehabilitation)</i></li> <li>• Ambulatory Surgical Center</li> </ul>	<p>Deductible/Coinsurance</p> <p>Deductible/Coinsurance</p> <p>Deductible/Coinsurance</p>
<b>Rehabilitation Services</b>	<ul style="list-style-type: none"> <li>• Therapy – Physical/Occupational/Speech</li> </ul>	<p>\$20 Copayment per visit</p>
<b>Ambulance Services</b>	<ul style="list-style-type: none"> <li>• Land and Air</li> </ul>	<p>No Charge</p>
<b>Home Health Care</b>	<ul style="list-style-type: none"> <li>• Limited to 40 visits per 12 month period <i>No coverage if not prior authorized</i></li> </ul>	<p>No Charge</p>

<b>Services</b>	<b>Benefits</b>	<b>Member Responsibility</b>
<b>Hospice Care</b>	<i>No Coverage if not prior authorized</i>	No Charge
<b>Durable Medical Equipment</b> <i>(Prior authorization required for DME/Orthotics over \$500 and prosthetics over \$1,000. No coverage if not prior authorized.)</i>	<ul style="list-style-type: none"> <li>• Prosthetics &amp; Orthotics</li> </ul>	Deductible/Coinsurance
<b>Diabetic Supplies</b>	<i>(Please refer to your Prescription Summary of Member Responsibility Table)</i>	
<b>Medical Supplies</b>	<i>Including insulin pump supplies</i>	No Charge
<b>Health Educational Programs</b>	<i>Please refer to the Certificate of Coverage for a list of benefits and limitations.</i>	No Charge
<b>Behavioral Health</b>	Mental Health and Chemical Dependency Services <ul style="list-style-type: none"> <li>• Inpatient – Limited to 10 days per year <i>No coverage if not prior authorized</i></li> <li>• Transitional – Limited to 20 days per year</li> <li>• Outpatient – Limited to 20 visits per year</li> </ul>	No Charge  No Charge No Charge
<b>Emergency/Urgent Care</b> <i>(Emergency room or hospital based urgent care facility)</i>	<ul style="list-style-type: none"> <li>• Emergency Room Services <i>(Copay waived if admitted inpatient within 24 hours)</i></li> <li>• Urgent Care</li> </ul>	\$50 Copayment per visit  \$20 Copayment per visit
<p><b>NOTE:</b> During regular office hours please call your PCP. The Time of day Hospital Urgent Care Services are available varies from facility to facility. Depending on the time of day and/or your condition, the facility may charge your services as Emergency Room. In this case, Emergency Room benefits will apply. If you need assistance in determining the urgency of a medical situation, call your Primary Care Practitioner's office or call Nurse Direct 24 hours a day, 7 days a week at 1-800-362-9900. Follow up emergency care must be directed by an NHP Practitioner.</p>		
<b>Prescription Drugs:</b>	<b>Please see Prescription Coverage Tab for prescription drug information.</b>	