HMO1031
NETWORK HMO-6 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.

IN-PLAN:	
Annual Deductible:	$750 per Member and $2,250 per Family each year
Member's Coinsurance:	30% of Eligible Expenses, unless otherwise specified
Out-of-Pocket Limit:	$5,000 per Member and $10,000 per Family each year

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

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
Wellness/Preventive Health	• Well Child Care Exams • Periodic Physical Exams • Immunizations • Routine Mammography Services	No Charge No Charge No Charge No Charge
Physician and Practitioner Services	**Primary Care Practitioner** • Office and Home visits • Inpatient visits **Specialty Physician** • Office and Home visits • Routine Eye Exams *(limited to one per 12 month period)* • Chiropractic office visits and manipulations • Allergy Immunizations • Accidental Dental Services • Radiation/Chemotherapy Services • Dialysis Services • Surgery & Anesthesiology Services • Routine Maternity *(pre & post natal care)* • Inpatient visits • Injectables administered in a Physician's office	 $20 Copayment per visit No Charge $20 Copayment per visit $20 Copayment per visit $20 Copayment per visit No Charge No Charge No Charge No Charge No Charge No Charge No Charge *Please refer to your Prescription drug benefit levels.*
Diagnostic Services	• X-Ray, Lab, Pathology *(practitioners office or outpatient)* • Diagnostic Mammography Services • PET Scans, MRI's, MRA's, CT Scans ***No coverage if not prior authorized*** • Stress Tests • Ultrasounds/Echocardiograms	No Charge No Charge No Charge No Charge No Charge
Hospital Services	• Inpatient Hospital ***No Coverage if not prior authorized*** • Outpatient Services or Procedures *(Including Cardiac Rehabilitation)* • Ambulatory Surgical Center	Deductible/Coinsurance Deductible/Coinsurance Deductible/Coinsurance
Rehabilitation Services	• Therapy – Physical/Occupational/Speech	$20 Copayment per visit
Ambulance Services	• Land and Air	Deductible/Coinsurance
Home Health Care	• Limited to 40 visits per 12 month period ***No coverage if not prior authorized***	No Charge

Services	Benefits	Member Responsibility
Hospice Care	*No Coverage if not prior authorized*	No Charge
Durable Medical Equipment *(Prior authorization required for DME/Orthotics over $500 and prosthetics over $1,000. No coverage if not prior authorized.)*	• Prosthetics & Orthotics	Deductible/Coinsurance
Diabetic Supplies	*(Please refer to your Prescription Summary of Member Responsibility Table)*	
Medical Supplies	*Including insulin pump supplies*	No Charge
Health Educational Programs	*Please refer to the Certificate of Coverage for a list of benefits and limitations.*	No Charge
Behavioral Health	Mental Health and Chemical Dependency Services • Inpatient – Limited to 10 days per year ***No coverage if not prior authorized*** • Transitional – Limited to 20 days per year • Outpatient – Limited to 20 visits per year	 No Charge No Charge No Charge
Emergency/Urgent Care *(Emergency room or hospital based urgent care facility)*	• Emergency Room Services ***(Copay waived if admitted inpatient within 24 hours)*** • Urgent Care	$100 Copayment per visit $20 Copayment per visit
NOTE: 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.		
Prescription Drugs:	**Please see Prescription Coverage Tab for prescription drug information.**	