



**HMO1009  
NETWORK HMO \$1,000 CO-CHOICE 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:	\$1,000 per Member and \$2,000 per Family each year
Member's Coinsurance:	20% 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 complete 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.

Services	Benefits	Member Responsibility
<b>Wellness/Preventive Health</b>	Well Child Care Exams Periodic Physical Exam Immunizations Routine Eye Exams <i>(limited to one per 12 month period)</i> Routine Mammography Services	No Charge No Charge No Charge No Charge No Charge
<b>Physician and Practitioner Services</b>	<b>Primary Care Practitioner</b> <ul style="list-style-type: none"> <li>• Office and Home visits</li> <li>• Inpatient visits</li> </ul> <b>Specialty Physician</b> <ul style="list-style-type: none"> <li>• Office and Home visits</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>	\$20 Copayment per visit No Charge  \$45 Copayment per visit \$20 Copayment per visit Deductible/Coinsurance \$45 Copayment per visit Deductible/Coinsurance Deductible/Coinsurance Deductible/Coinsurance Deductible/Coinsurance No Charge <i>Please refer to your Prescription drug benefit levels.</i>
<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, MRIs, MRA's, CT Scans <i>No coverage if not prior authorized</i></li> <li>• Stress Tests</li>   <li>• Ultrasounds/ Echocardiogram</li> </ul>	Deductible/Coinsurance Deductible/Coinsurance  \$100 Copay/Coinsurance per procedure  \$100 Copay/Coinsurance per procedure  \$50 Copay/Coinsurance per procedure
<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>	Deductible/Coinsurance  Deductible/Coinsurance  Deductible/Coinsurance
<b>Rehabilitation Services</b>	<ul style="list-style-type: none"> <li>• Therapy – Physical/Occupational/Speech</li> </ul>	Deductible/Coinsurance
<b>Ambulance Services</b>	<ul style="list-style-type: none"> <li>• Land and Air</li> </ul>	\$100 Copay/Coinsurance per transport
<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>	Deductible/Coinsurance

**NETWORK HEALTH PLAN**

<b>Services</b>	<b>Benefits</b>	<b>Member Responsibility</b>
<b>Hospice Care</b>	<i>No coverage if not prior authorized</i>	Deductible/Coinsurance
<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 the Prescription Summary of Member Responsibility Table.</i>	
<b>Medical Supplies</b>	<i>Including insulin pump supplies.</i>	Deductible/Coinsurance
<b>Health Education Programs</b>	Please refer to Certificate of Coverage for list of benefits & limitations	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</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> </ul>	\$100 Copay/Coinsurance per visit
	<ul style="list-style-type: none"> <li>• Urgent Care</li> </ul>	Deductible/Coinsurance
<p><b>NOTE: During regular office hours please call your PCP. The Time of day Hospital Urgent Care Service 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.</b></p>		
<b>Prescription Drugs:</b>	<b>Please see Prescription Coverage Tab for prescription drug information.</b>	

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