



HSAHMO1006
H S A HMO \$2,000-100% PLAN
SUMMARY OF MEMBER RESPONSIBILITY TABLE
“A Health Savings Account Qualified Plan”

This Summary reflects your member out-of-pocket expenses. For Family coverage, benefits are not paid for any one Family member, until the entire Family deductible is met.

Out of pocket expenses incurred to satisfy deductible, coinsurance and copayments, apply toward the out of pocket limit. Costs of non-covered services, charges in excess of usual and customary amount and benefits reduced when prior authorization has not been obtained, will not apply toward the out of pocket limit.

<u>IN PLAN:</u>	
Annual Deductible:	\$2,000 Self only coverage and \$4,000 Family coverage per year
Member’s Coinsurance:	0 % of Eligible Expenses, unless otherwise specified
Out of Pocket Limit:	\$2,000 Self only coverage and \$4,000 Family coverage per 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
Wellness/Preventive Health	Well Child Care Exams Periodic Physical Exam Immunizations Routine Mammography Services	No Charge No Charge No Charge No Charge
Physician and Practitioner Services	<p>Primary Care Practitioner</p> <ul style="list-style-type: none"> • Office and Home visits • Inpatient visits <p>Specialty Physician</p> <ul style="list-style-type: none"> • Office and Home visits • Routine Eye Exams <i>(limited to one per 12 month period)</i> • Allergy Immunizations • Accidental Dental Services • Radiation/Chemotherapy Services • Dialysis services • Surgery & Anesthesiology services • Chiropractic office visits and manipulations • Routine Maternity <i>(pre & post natal care)</i> • Inpatient visits • Injectables administered in a Physician's office 	Deductible Deductible Deductible Deductible Deductible Deductible Deductible Deductible Deductible Deductible Deductible Deductible <i>Please refer to your prescription drug benefit levels</i>
Diagnostic Services	<ul style="list-style-type: none"> • X-Ray, Lab, Pathology • Diagnostic Mammography Services <ul style="list-style-type: none"> • PET Scans, MRIs, MRA's, CT Scans <i>No coverage if not prior authorized</i> <ul style="list-style-type: none"> • Stress Tests <ul style="list-style-type: none"> • Ultrasounds/ Echocardiogram 	Deductible Deductible Deductible Deductible
Hospital Services	<ul style="list-style-type: none"> • Inpatient Hospital <i>No coverage if not prior authorized</i> 	Deductible
	<ul style="list-style-type: none"> • Outpatient Services or Procedures <i>(Including Cardiac Rehabilitation)</i> 	Deductible
	<ul style="list-style-type: none"> • Ambulatory Surgical Center 	Deductible
Rehabilitation Services	<ul style="list-style-type: none"> • Therapy – Physical/Occupational/Speech 	Deductible
Ambulance Services	<ul style="list-style-type: none"> • Land and Air 	Deductible

Services	Benefits	Member Responsibility
Home Health Care	<ul style="list-style-type: none"> Limited to 40 visits per 12 month period <i>No coverage if not prior authorized</i>	Deductible
Hospice Care	<i>No coverage if not prior authorized</i>	Deductible
Durable Medical Equipment <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"> Prosthetics & Orthotics 	Deductible
Diabetic Supplies	<i>Please refer to the Prescription Drug Summary of Member Responsibility Table.</i>	Deductible
Medical Supplies	<i>Including insulin pump supplies.</i>	Deductible
Health Education Programs	Please refer to Certificate of Coverage for list of benefits & limitations	No Charge
Behavioral Health	Mental Health and Chemical Dependency Services <ul style="list-style-type: none"> Inpatient – Limited to 10 days per year <i>No coverage if not prior authorized</i> <ul style="list-style-type: none"> Transitional – Limited to 20 days per year Outpatient – Limited to 20 visits per year 	Deductible Deductible Deductible
Emergency/Urgent Care <i>(Emergency room or hospital based urgent care facility)</i>	<ul style="list-style-type: none"> Emergency Room Services 	Deductible
	<ul style="list-style-type: none"> Urgent Care Facility 	Deductible
<p>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.</p>		
Prescription Drugs: Prescription drugs dispensed through a NHP participating retail or mail order pharmacy and prescribed by either a NHP participating or non-participating practitioner, for up to a 31 day supply at retail and 90 days at mail order	<ul style="list-style-type: none"> Pharmacy 	Deductible