



**HMO1064
NETWORK HMO \$3,500 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:	\$3,500 per Member and \$7,000 per Family each year
Member's Coinsurance:	20% of Eligible Expenses, unless otherwise specified
Out-of-Pocket Limit:	\$4,500 per Member and \$9,000 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.

NETWORK HEALTH PLAN

Services	Benefits	Member Responsibility
Wellness/Preventive Health	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
Physician and Practitioner Services	Primary Care Practitioner <ul style="list-style-type: none"> • Office and Home visits • Inpatient visits Specialty Physician <ul style="list-style-type: none"> • Office and Home visits • Chiropractic office visits and manipulations • Allergy Immunizations • Accidental Dental Services • Radiation/Chemotherapy Services • Dialysis services • Surgery & Anesthesiology services • Routine Maternity <i>(pre & post natal care)</i> • Inpatient visits • Injectables administered in a Physician's office 	\$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>
Diagnostic Services	<ul style="list-style-type: none"> • X-Ray, Lab, Pathology <i>(practitioners office or outpatient)</i> • Diagnostic Mammography Services • PET Scans, MRIs, MRA's, CT Scans <i>No coverage if not prior authorized</i> • Stress Tests • Ultrasounds/ Echocardiogram 	Deductible/Coinsurance Deductible/Coinsurance \$100 Copay/Coinsurance per procedure \$100 Copay/Coinsurance per procedure \$50 Copay/Coinsurance per procedure
Hospital Services	<ul style="list-style-type: none"> • Inpatient Hospital <i>No coverage if not prior authorized</i> • Outpatient Services or Procedures <i>(Including Cardiac Rehabilitation)</i> • Ambulatory Surgical Center 	Deductible/Coinsurance Deductible/Coinsurance Deductible/Coinsurance
Rehabilitation Services	<ul style="list-style-type: none"> • Therapy – Physical/Occupational/Speech 	Deductible/Coinsurance
Ambulance Services	<ul style="list-style-type: none"> • Land and Air 	\$100 Copay/Coinsurance per transport
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/Coinsurance

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Services	Benefits	Member Responsibility
Hospice Care	<i>No coverage if not prior authorized</i>	Deductible/Coinsurance
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/Coinsurance
Diabetic Supplies	<i>Please refer to the Prescription Summary of Member Responsibility Table.</i>	
Medical Supplies	<i>Including insulin pump supplies.</i>	Deductible/Coinsurance
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 	No Charge No Charge No Charge
Emergency/Urgent Care <i>(Emergency room or hospital based urgent care facility)</i>	<ul style="list-style-type: none"> • Emergency Room Services <i>(Copay waived if admitted inpatient within 24 hours)</i> 	\$100 Copay/Coinsurance per visit
	<ul style="list-style-type: none"> • Urgent Care 	Deductible/Coinsurance
<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:	Please see Prescription Coverage Tab for prescription drug information.	

NETWORK HEALTH PLAN