



**H2000 COCHOICE
CO-CHOICE HMO 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 when the services are provided by a Network Health Plan participating provider.

The following will not apply toward the out-of-pocket limit: copayments, non-covered services and denied benefits when prior authorization is not obtained.

IN NETWORK:

Annual Deductible:	\$2,000 per Member and \$4,000 per Family each Benefit year
Member's Coinsurance:	20% of Eligible Expenses, unless otherwise specified
Out-of-Pocket Limit:	\$4,000 per Member and \$8,000 per Family each Benefit year

Maximum Policy Benefit:	\$5,000,000 per Member per Lifetime
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This is a summary of your health care coverage.

All benefits are subject to the terms of your policy. Please refer to your Certificate of Coverage and any applicable Riders for detailed benefit information, restrictions, limitations and exclusions that apply to that coverage.

Please contact Network Health Plan's Customer Service Department at 1-800-826-0940 for assistance in understanding your health care benefits.

Services	Benefits	Member Responsibility
Preventive Health	• Child Preventive Visit	No Charge
	• Adult Preventive Visit	No Charge
	• Immunizations	No Charge
	• Routine Mammography	No Charge
	• Routine Vision Exam	No Charge
Physician and Practitioner Services	• Primary Care Practitioner Home & Office Visits	\$30 Copay per visit
	• Specialist Home & Office Visits	\$60 Copay per visit
	• Primary Care Practitioner Inpatient Visits	No Charge
	• Specialist Inpatient Visits	No Charge
	• Allergy Immunizations	Deductible/Coinsurance
	• Accidental Dental Services	\$60 Copay per visit
	• Radiation/Chemotherapy Services	Deductible/Coinsurance
	• Dialysis Services	Deductible/Coinsurance
	• Surgery & Anesthesiology Services	Deductible/Coinsurance
	• Maternity Care	No Charge
	• Chiropractic Office Visits & Manipulations	\$30 Copay per visit
	• Medications Administered in a Physician's Office	Please refer to your Prescription Drug Rider
	Diagnostic Services	• X-Ray, Lab, Pathology Practitioners office or outpatient
• Diagnostic Mammography Services Practitioners office or outpatient		Deductible/Coinsurance
• PET Scans, MRIs, MRA's, CT Scans		\$100 Copay/Coinsurance per procedure
• Stress Tests		\$100 Copay/Coinsurance per procedure
• Ultrasounds/ Echocardiograms		\$50 Copay/Coinsurance per procedure
Hospital Services	• Inpatient Hospital	Deductible/Coinsurance
	• Outpatient Services or Procedures Including Cardiac Rehabilitation	Deductible/Coinsurance
	• Ambulatory Surgical Center	Deductible/Coinsurance
Rehabilitation Services	• Therapy – Physical/Occupational/Speech	Deductible/Coinsurance
Home Health Care		Deductible/Coinsurance
Hospice Care		Deductible/Coinsurance

Services	Benefits	Member Responsibility
Durable Medical Equipment		Deductible/Coinsurance
Medical Supplies	Including insulin pump supplies	Deductible/Coinsurance
Behavioral Health Mental Health and Chemical Dependency Services	<ul style="list-style-type: none"> • Inpatient Limited to 10 days per Benefit year • Transitional Limited to 20 days per Benefit year • Outpatient Limited to 20 visits per Benefit year 	Deductible/Coinsurance \$60 Copay per visit \$60 Copay per visit
Ambulance Services	• Land and Air	\$100 Copay/Coinsurance per transport
Emergency/Urgent Care	<ul style="list-style-type: none"> • Emergency Room Services • Urgent Care 	\$200 Copay per visit \$100 Copay per visit
Health Education Programs	Please refer to Certificate of Coverage for list of benefits & limitations	No Charge
Diabetic Supplies	Please refer to the Prescription Summary of Member Responsibility Table	
Prescription Drugs:	Please see the Prescription Summary of Member Responsibility Table for prescription drug information, including medications administered in the Office or Outpatient setting.	