



**P2000 COCHOICE
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 In-Network out-of-pocket limit when the services are provided by a Network Health Plan Participating Provider.

Out-of-pocket expenses incurred when the services are not provided by a Network Health Plan Participating Provider will apply toward the out of network benefits.

The following will not apply towards the out-of-pocket limit: copayments, non-covered services, denied benefits, and the benefit reduction amount 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

OUT-OF-NETWORK:

Coverage for Out-of-Network services which require Prior Authorization as listed in your Point of Service Plan Rider will have a 10% benefit reduction if the services are not Prior Authorized.

Annual Deductible:	\$4,000 per Member and \$8,000 per Family each Benefit year
Member's Coinsurance:	40% of Eligible Expenses, unless otherwise specified
Out of Pocket Limit:	\$8,000 per Member and \$16,000 per Family each Benefit year

Maximum Policy Benefit:	\$5,000,000 per Member per Lifetime
In-Network & Out-of-Network benefits combined	

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

Services	Benefits	Member Responsibility	
		In-Network	Out-of-Network
Hospice Care		Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equipment		Deductible/Coinsurance	Deductible/Coinsurance
Medical Supplies	Including insulin pump supplies	Deductible/Coinsurance	Deductible/Coinsurance
Behavioral Health Mental Health & Chemical Dependency Services	• Inpatient Limited to 10 days per Benefit year	Deductible/Coinsurance	Deductible/Coinsurance
	• Transitional Limited to 20 days per Benefit year	\$60 Copay per visit	Deductible/Coinsurance
	• Outpatient Limited to 20 days per Benefit year	\$60 Copay per visit	Deductible/Coinsurance
Ambulance Services	• Land and Air	\$100 Copay per transport	
Emergency/Urgent Care	• Emergency Room Services	\$200 Copay per visit	
	• Urgent Care	\$100 Copay per visit	Deductible/Coinsurance
Health Education Programs	Please refer to the Certificate of Coverage for list of benefits & limitations	No Charge	Not Covered
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.		