



**P2500 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**

<b>Annual Deductible:</b>	<b>\$2,500 per Member and \$5,000 per Family each Benefit year</b>
<b>Member's Coinsurance:</b>	<b>20% of Eligible Expenses, unless otherwise specified</b>
<b>Out-of-Pocket Limit:</b>	<b>\$4,500 per Member and \$9,000 per Family each Benefit year</b>

**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.**

<b>Annual Deductible:</b>	<b>\$5,000 per Member and \$10,000 per Family each Benefit year</b>
<b>Member's Coinsurance:</b>	<b>40% of Eligible Expenses, unless otherwise specified</b>
<b>Out of Pocket Limit:</b>	<b>\$9,000 per Member and \$18,000 per Family each Benefit year</b>

<b>Maximum Policy Benefit:</b>	<b>\$5,000,000 per Member per Lifetime</b>
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
<b>Preventive Health</b>	• 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
<b>Physician and Practitioner Services</b>	• 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	
<b>Diagnostic Services</b>	• 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
<b>Hospital Services</b>	• Inpatient Hospital	Deductible/Coinsurance	Deductible/Coinsurance
	• Outpatient Services or Procedures Including Cardiac Rehabilitation	Deductible/Coinsurance	Deductible/Coinsurance
	• Ambulatory Surgical Center	Deductible/Coinsurance	Deductible/Coinsurance
<b>Rehabilitation Services</b>	• Therapy –Physical/Occupational/Speech	Deductible/Coinsurance	Deductible/Coinsurance
<b>Home Health Care</b>		Deductible/Coinsurance	Deductible/Coinsurance

Services	Benefits	Member Responsibility	
		In-Network	Out-of-Network
<b>Hospice Care</b>		Deductible/Coinsurance	Deductible/Coinsurance
<b>Durable Medical Equipment</b>		Deductible/Coinsurance	Deductible/Coinsurance
<b>Medical Supplies</b>	Including insulin pump supplies	Deductible/Coinsurance	Deductible/Coinsurance
<b>Behavioral Health</b> 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
<b>Ambulance Services</b>	• Land and Air	\$100 Copay per transport	
<b>Emergency/Urgent Care</b>	• Emergency Room Services	\$200 Copay per visit	
	• Urgent Care	\$100 Copay per visit	Deductible/Coinsurance
<b>Health Education Programs</b>	Please refer to the Certificate of Coverage for list of benefits & limitations	No Charge	Not Covered
<b>Diabetic Supplies</b>	Please refer to the Prescription Summary of Member Responsibility Table		
<b>Prescription Drugs:</b>	Please see the Prescription Summary of Member Responsibility Table for prescription drug information, including medications administered in the Office or Outpatient setting.		