HSA ELIGIBLE HMO (NARROW) PLAN
SUMMARY OF MEMBER RESPONSIBILITY TABLE

This Summary reflects your Out-Of-Pocket expenses.

Non-covered services and denied Benefits will not apply to your Out-Of-Pocket Limit.

For Family coverage, Benefits are not paid for any one Family member, until the entire Family Deductible is met.

IN-NETWORK:	
Annual Deductible:	**$1,500 Self only coverage or $3,000 per Family each Benefit year**
Member's Co-Insurance:	**0% of Eligible Expenses, unless otherwise specified**
Out-Of-Pocket Limit:	**$1,500 Self only coverage or $3,000 per Family each Benefit year**
Out-Of-Pocket expenses incurred to satisfy Deductible will apply to the Out-Of-Pocket Limit when the services are provided by a Network Health Plan Participating Provider.	

This is a summary of your health care coverage.

All Benefits are subject to the terms, limitations and exclusions of the Certificate of Coverage. Please refer to your Certificate of Coverage, Preventive Coverage or Preventive Services Guide, and any applicable Riders for detailed Benefits information, eligible services and coverage guidelines. Network Health Plan's coverage includes Benefits for all State of Wisconsin and Federal mandated benefits.

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	Please refer to your Member Handbook for a copy of the Preventive Services Guide document.	No Charge
	Routine Vision Exam	No Charge
Physician and Practitioner Services	Primary Care Practitioner Home & Office Visits *Including Behavioral Health & Substance Abuse*	Deductible
	Specialist Home & Office Visits	Deductible
	Virtual Visits	Deductible
	Primary Care Practitioner Inpatient Visits	Deductible
	Specialist Inpatient Visits	Deductible
	All other outpatient services/procedures performed in a Practitioner's office not otherwise listed on this table	Deductible
	Accidental Dental Services	Deductible
	Maternity Care	Deductible
	Chiropractic Office Visits & Manipulations	Deductible
	Medications administered in the Practitioner's office	Please refer to your Prescription Benefit Summary of Member Responsibility Table
Chemotherapy Medication	Administered in the Practitioner's office, Outpatient Facility or in the home	Please refer to your Prescription Benefit Summary of Member Responsibility Table
Diagnostic Services	X-Ray, Lab, Pathology Practitioner's office or outpatient	Deductible
	Diagnostic Mammography Services Practitioners office or outpatient	Deductible
	PET Scans, MRIs, MRA's, CT Scans	Deductible
	Stress Tests	Deductible
	Ultrasounds/ Echocardiograms	Deductible
Hospital Services	Inpatient Services *Including Behavioral Health & Substance Abuse*	Deductible
	Outpatient Services or Procedures *Including Cardiac Rehabilitation, Radiation Therapy, Dialysis, Behavioral Health & Substance Abuse*	Deductible
	Ambulatory Surgical Center	Deductible
Rehabilitation Services	Therapy – Physical/Occupational/Speech	Deductible
Home Health Care		Deductible
Hospice Care		Deductible
Durable Medical Equipment		Deductible

Services	Benefits	Member Responsibility
Medical Supplies	Including insulin pump supplies	Deductible
Ambulance Services	Land and Air	Deductible
Emergency/Urgent Care	Emergency Room Services Urgent Care	Deductible Deductible
Health Education Programs	Please refer to Certificate of Coverage for list of Benefits & limitations	No Charge
Diabetic Supplies	Please refer to the Prescription Benefit Summary of Member Responsibility Table	
Prescription Drugs:	Please see the Prescription Benefit Summary of Member Responsibility Table for prescription drug information, including medications administered in the Office or Outpatient setting.	

HSA ELIGIBLE HMO (NARROW) PLAN
SUMMARY OF MEMBER RESPONSIBILITY TABLE

This Summary reflects your Out-Of-Pocket expenses.

Non-covered services and denied Benefits will not apply to your Out-Of-Pocket Limit.

For Family coverage, Benefits are not paid for any one Family member, until the entire Family Deductible is met.

IN-NETWORK:	
Annual Deductible:	**$2,000 Self only coverage or $4,000 per Family each Benefit year**
Member's Co-Insurance:	**0% of Eligible Expenses, unless otherwise specified**
Out-Of-Pocket Limit:	**$2,000 Self only coverage or $4,000 per Family each Benefit year**
Out-Of-Pocket expenses incurred to satisfy Deductible will apply to the Out-Of-Pocket Limit when the services are provided by a Network Health Plan Participating Provider.	

This is a summary of your health care coverage.

All Benefits are subject to the terms, limitations and exclusions of the Certificate of Coverage. Please refer to your Certificate of Coverage, Preventive Coverage or Preventive Services Guide, and any applicable Riders for detailed Benefits information, eligible services and coverage guidelines. Network Health Plan's coverage includes Benefits for all State of Wisconsin and Federal mandated benefits.

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	Please refer to your Member Handbook for a copy of the Preventive Services Guide document.	No Charge
	Routine Vision Exam	No Charge
Physician and Practitioner Services	Primary Care Practitioner Home & Office Visits *Including Behavioral Health & Substance Abuse*	Deductible
	Specialist Home & Office Visits	Deductible
	Virtual Visits	Deductible
	Primary Care Practitioner Inpatient Visits	Deductible
	Specialist Inpatient Visits	Deductible
	All other outpatient services/procedures performed in a Practitioner's office not otherwise listed on this table	Deductible
	Accidental Dental Services	Deductible
	Maternity Care	Deductible
	Chiropractic Office Visits & Manipulations	Deductible
	Medications administered in the Practitioner's office	Please refer to your Prescription Benefit Summary of Member Responsibility Table
Chemotherapy Medication	Administered in the Practitioner's office, Outpatient Facility or in the home	Please refer to your Prescription Benefit Summary of Member Responsibility Table
Diagnostic Services	X-Ray, Lab, Pathology Practitioner's office or outpatient	Deductible
	Diagnostic Mammography Services Practitioners office or outpatient	Deductible
	PET Scans, MRIs, MRA's, CT Scans	Deductible
	Stress Tests	Deductible
	Ultrasounds/ Echocardiograms	Deductible
Hospital Services	Inpatient Services *Including Behavioral Health & Substance Abuse*	Deductible
	Outpatient Services or Procedures *Including Cardiac Rehabilitation, Radiation Therapy, Dialysis, Behavioral Health & Substance Abuse*	Deductible
	Ambulatory Surgical Center	Deductible
Rehabilitation Services	Therapy – Physical/Occupational/Speech	Deductible
Home Health Care		Deductible
Hospice Care		Deductible
Durable Medical Equipment		Deductible

Services	Benefits	Member Responsibility
Medical Supplies	Including insulin pump supplies	Deductible
Ambulance Services	Land and Air	Deductible
Emergency/Urgent Care	Emergency Room Services Urgent Care	Deductible Deductible
Health Education Programs	Please refer to Certificate of Coverage for list of Benefits & limitations	No Charge
Diabetic Supplies	Please refer to the Prescription Benefit Summary of Member Responsibility Table	
Prescription Drugs:	Please see the Prescription Benefit Summary of Member Responsibility Table for prescription drug information, including medications administered in the Office or Outpatient setting.	

HSA ELIGIBLE HMO (NARROW) PLAN
SUMMARY OF MEMBER RESPONSIBILITY TABLE

This Summary reflects your Out-Of-Pocket expenses.

Non-covered services and denied Benefits will not apply to your Out-Of-Pocket Limit.

IN-NETWORK:	
Annual Deductible:	**$3,000 per Member and $6,000 per Family each Benefit year**
Member's Co-Insurance:	**0% of Eligible Expenses, unless otherwise specified**
Out-Of-Pocket Limit:	**$3,000 per Member and $6,000 per Family each Benefit year**
Out-Of-Pocket expenses incurred to satisfy Deductible will apply to the Out-Of-Pocket Limit when the services are provided by a Network Health Plan Participating Provider.	

This is a summary of your health care coverage.

All Benefits are subject to the terms, limitations and exclusions of the Certificate of Coverage. Please refer to your Certificate of Coverage, Preventive Coverage or Preventive Services Guide, and any applicable Riders for detailed Benefits information, eligible services and coverage guidelines. Network Health Plan's coverage includes Benefits for all State of Wisconsin and Federal mandated benefits.

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	Please refer to your Member Handbook for a copy of the Preventive Services Guide document.	No Charge
	Routine Vision Exam	No Charge
Physician and Practitioner Services	Primary Care Practitioner Home & Office Visits *Including Behavioral Health & Substance Abuse*	Deductible
	Specialist Home & Office Visits	Deductible
	Virtual Visits	Deductible
	Primary Care Practitioner Inpatient Visits	Deductible
	Specialist Inpatient Visits	Deductible
	All other outpatient services/procedures performed in a Practitioner's office not otherwise listed on this table	Deductible
	Accidental Dental Services	Deductible
	Maternity Care	Deductible
	Chiropractic Office Visits & Manipulations	Deductible
	Medications administered in the Practitioner's office	Please refer to your Prescription Benefit Summary of Member Responsibility Table
Chemotherapy Medication	Administered in the Practitioner's office, Outpatient Facility or in the home	Please refer to your Prescription Benefit Summary of Member Responsibility Table
Diagnostic Services	X-Ray, Lab, Pathology Practitioner's office or outpatient	Deductible
	Diagnostic Mammography Services Practitioners office or outpatient	Deductible
	PET Scans, MRIs, MRA's, CT Scans	Deductible
	Stress Tests	Deductible
	Ultrasounds/ Echocardiograms	Deductible
Hospital Services	Inpatient Services *Including Behavioral Health & Substance Abuse*	Deductible
	Outpatient Services or Procedures *Including Cardiac Rehabilitation, Radiation Therapy, Dialysis, Behavioral Health & Substance Abuse*	Deductible
	Ambulatory Surgical Center	Deductible
Rehabilitation Services	Therapy – Physical/Occupational/Speech	Deductible
Home Health Care		Deductible
Hospice Care		Deductible
Durable Medical Equipment		Deductible

Services	Benefits	Member Responsibility
Medical Supplies	Including insulin pump supplies	Deductible
Ambulance Services	Land and Air	Deductible
Emergency/Urgent Care	Emergency Room Services Urgent Care	Deductible Deductible
Health Education Programs	Please refer to Certificate of Coverage for list of Benefits & limitations	No Charge
Diabetic Supplies	Please refer to the Prescription Benefit Summary of Member Responsibility Table	
Prescription Drugs:	Please see the Prescription Benefit Summary of Member Responsibility Table for prescription drug information, including medications administered in the Office or Outpatient setting.	

100% HSA – HMO (NARROW)
PRESCRIPTION BENEFIT SUMMARY OF MEMBER RESPONSIBILITY TABLE

NOTE: Upon reaching the out-of-pocket limit, prescription drugs, insulin, diabetic supplies, and specialty products will be covered at 100%.

Please refer to the Summary of Member Responsibility Table for annual deductible and out-of-pocket limit.

PRESCRIPTION DRUGS, APPROVED CONTRACEPTIVES, INSULIN, AND DIABETIC SUPPLIES:	
a. Retail Pharmacy	Prescription drugs, insulin, and diabetic supplies prescribed by a NHP participating practitioner and dispensed through a NHP participating retail pharmacy: Subject to deductible and out-of-pocket limit listed in the Summary of Member Responsibility Table Diabetic supplies refers to, for example, alcohol swabs/wipes, lancets, lancet devices, insulin syringes and needles, glucose monitors/meters, glucose control solutions, and blood and urine glucose and ketone test strips. All prescriptions, or refills, can be dispensed in quantities up to a 31 day supply. In addition: • Approved contraceptives including over the counter (OTC) products listed in the Preferred Drug List can be filled in quantities up to an 84 day supply at no cost. • Insulin and diabetic supplies can be filled in quantities up to a 91 day supply For insulin pump supplies, please refer to your medical supply benefit listed on your Summary of Member Responsibility Table.
b. Mail Order Pharmacy	Prescription drugs, insulin, and diabetic supplies prescribed by a NHP participating practitioner and dispensed through a NHP participating mail order pharmacy in quantities up to a 91 day supply: Subject to deductible and out-of-pocket limit listed in the Summary of Member Responsibility Table NOTE: Preferred Specialty Products and Non-Preferred Specialty Products are not available through the mail order pharmacy. • Approved contraceptives including over the counter (OTC) products listed in the Preferred Drug List can be filled in quantities up to an 84 day supply at no cost.

SPECIALTY PRODUCTS:	
c. Specialty Pharmacy	Specialty Products prescribed by a NHP participating practitioner and dispensed through a NHP participating specialty pharmacy in quantities up to a 31 day supply: Subject to deductible and out-of-pocket limit listed in the Summary of Member Responsibility Table
d. Practitioner's Office	Specialty Products prescribed by a NHP participating practitioner and administered in a NHP participating practitioner's office: Subject to deductible and out-of-pocket limit listed in the Summary of Member Responsibility Table • Approved contraceptives administered in the office for contraceptive purposes are covered at no charge.

All benefits are subject to the terms, limitations and exclusions of the Certificate of Coverage. Please refer to your Certificate of Coverage, Preventive Coverage or Preventive Services Guide, and any applicable Riders for detailed benefits information, eligible services and coverage guidelines. Network Health Plan's coverage includes benefits for all State of Wisconsin and Federal mandated benefits.

Benefits for Non-Specialty injectable medications administered in a NHP participating practitioner's office are covered under the medical benefit and will follow the member responsibility outlined above in Section a. Retail Pharmacy.

If the practitioner indicates "Dispense As Written", or if the member requests the brand name product for a medication where a generic is available, the member must pay the applicable ancillary charge. The ancillary charge is the cost difference between the brand name product and the generic product up to a maximum of $200 per month's supply. The ancillary charge will not count towards the deductible or out-of-pocket limit. When generic substitution conflicts with state regulations or restrictions the pharmacist must gain approval from the prescriber to use the generic equivalent.

To receive a copy of the Network Health Plan Preferred Drug List, please call Customer Service at 1-800-826-0940, or visit www.networkhealth.com.

HSA ELIGILBE POS PLAN
SUMMARY OF MEMBER RESPONSIBILITY TABLE

This Summary reflects your member Out-Of-Pocket expenses.

Non-covered services and denied Benefits will not apply to your Out-Of-Pocket Limit.

For Family coverage, Benefits are not paid for any one Family member, until the entire Family Deductible is met.

IN-NETWORK:

Annual Deductible:	**$1,500 Self only coverage or $3,000 per Family each Benefit year**
Member's Co-Insurance:	**0% of Eligible Expenses, unless otherwise specified**
Out-Of-Pocket Limit:	**$1,500 Self only coverage or $3,000 per Family each Benefit year**

Out-Of-Pocket expenses incurred to satisfy Deductible will apply to the Out-Of-Pocket Limit when the services are provided by a Network Health Plan Participating Provider.

OUT-OF-NETWORK:	**Out-of-Network services for State Mandated benefits requiring Prior Authorization will have a 10% benefit reduction if the services are not Prior Authorized. Please refer to your Point of Service Plan Rider for a list of services that require prior authorization.**
Annual Deductible:	**$2,500 Self only coverage or $5,000 per Family each Benefit year**
Member's Co-Insurance:	**20% of Eligible Expenses, unless otherwise specified**
Out-Of-Pocket Limit:	**$4,500 Self only coverage or $9,000 per Family each Benefit year**

Out-Of-Pocket expenses incurred to satisfy Deductible and Co-Insurance will apply to the Out-of-Network Out-Of-Pocket Limit when the services are not provided by a Network Health Plan Participating Provider.

This is a summary of your health care coverage.

All Benefits are subject to the terms, limitations and exclusions of the Certificate of Coverage. Please refer to your Certificate of Coverage, Preventive Coverage or Preventive Services Guide, and any applicable Riders for detailed Benefits information, eligible services and coverage guidelines. Network Health Plan's coverage includes Benefits for all State of Wisconsin and Federal mandated benefits.

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	Please refer to your Member Handbook for a copy of the Preventive Services Guide document.	No Charge	Deductible/Co-Insurance
	Routine Vision Exam	No Charge	Deductible/Co-Insurance
Physician and Practitioner Services	Primary Care Practitioner Home & Office Visits *Including Behavioral Health & Substance Abuse*	Deductible	Deductible/Co-Insurance
	Specialist Home & Office Visits	Deductible	Deductible/Co-Insurance
	Virtual Visits	Deductible	Not Covered
	Primary Care Practitioner Inpatient Visits	Deductible	Deductible/Co-Insurance
	Specialist Inpatient Visits	Deductible	Deductible/Co-Insurance
	All other outpatient services/procedures performed in a Practitioner's office not otherwise listed on this table	Deductible	Deductible/Co-Insurance
	Accidental Dental Services	Deductible	
	Maternity Care	Deductible	Deductible/Co-Insurance
	Chiropractic Office Visits & Manipulations	Deductible	Deductible/Co-Insurance
	Medications administered in the Practitioners office	Please refer to your Prescription Benefit Summary of Member Responsibility Table	
Chemotherapy Medication	Administered in the Practitioner's office, Outpatient Facility or in the home	Please refer to your Prescription Benefit Summary of Member Responsibility Table	
Diagnostic Services	X-Ray, Lab, Pathology Practitioners office or outpatient	Deductible	Deductible/Co-Insurance
	Diagnostic Mammography Services Practitioners office or outpatient	Deductible	Deductible/Co-Insurance
	PET Scans, MRIs, MRA's, CT Scans	Deductible	Deductible/Co-Insurance
	Stress Tests	Deductible	Deductible/Co-Insurance
	Ultrasounds/ Echocardiograms	Deductible	Deductible/Co-Insurance
Hospital Services	Inpatient Services *Including Behavioral Health & Substance Abuse*	Deductible	Deductible/Co-Insurance
	Outpatient Services or Procedures *Including Cardiac Rehabilitation, Radiation Therapy, Dialysis, Behavioral Health & Substance Abuse*	Deductible	Deductible/Co-Insurance
	Ambulatory Surgical Center	Deductible	Deductible/Co-Insurance
Rehabilitation Services	Therapy – Physical/Occupational/Speech	Deductible	Deductible/Co-Insurance
Home Health Care		Deductible	Deductible/Co-Insurance
Hospice Care		Deductible	Deductible/Co-Insurance
Durable Medical Equipment		Deductible	Deductible/Co-Insurance

Services	Benefits	Member Responsibility	
		In-Network	**Out-of-Network**
Medical Supplies	Including insulin pump supplies	Deductible	Deductible/Co-Insurance
Ambulance Services	Land and Air	Deductible	
Emergency/Urgent Care	Emergency Room Services	Deductible	
	Urgent Care	Deductible	Deductible/Co-Insurance
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 Benefit Summary of Member Responsibility Table		
Prescription Drugs:	Please see the Prescription Benefit Summary of Member Responsibility Table for prescription drug information, including medications administered in the Office or Outpatient setting.		

HSA ELIGLBE POS PLAN
SUMMARY OF MEMBER RESPONSIBILITY TABLE

This Summary reflects your member Out-Of-Pocket expenses.

Non-covered services and denied Benefits will not apply to your Out-Of-Pocket Limit.

For Family coverage, Benefits are not paid for any one Family member, until the entire Family Deductible is met.

IN-NETWORK:

Annual Deductible:	**$2,000 Self only coverage or $4,000 per Family each Benefit year**
Member's Co-Insurance:	**0% of Eligible Expenses, unless otherwise specified**
Out-Of-Pocket Limit:	**$2,000 Self only coverage or $4,000 per Family each Benefit year**

Out-Of-Pocket expenses incurred to satisfy Deductible will apply to the In-Network Out-Of-Pocket Limit when the services are provided by a Network Health Plan Participating Provider

OUT-OF-NETWORK:	**Out-of-Network services for State Mandated benefits requiring Prior Authorization will have a 10% benefit reduction if the services are not Prior Authorized. Please refer to your Point of Service Plan Rider for a list of services that require prior authorization.**
Annual Deductible:	**$3,000 Self only coverage or $6,000 per Family each Benefit year**
Member's Co-Insurance:	**20% of Eligible Expenses, unless otherwise specified**
Out-Of-Pocket Limit:	**$5,000 Self only coverage or $10,000 per Family each Benefit year**

Out-Of-Pocket expenses incurred to satisfy Deductible and Co-Insurance will apply to the Out-of-Network Out-Of-Pocket Limit when the services are not provided by a Network Health Plan Participating Provider.

This is a summary of your health care coverage.

All Benefits are subject to the terms, limitations and exclusions of the Certificate of Coverage. Please refer to your Certificate of Coverage, Preventive Coverage or Preventive Services Guide, and any applicable Riders for detailed Benefits information, eligible services and coverage guidelines. Network Health Plan's coverage includes Benefits for all State of Wisconsin and Federal mandated benefits.

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	Please refer to your Member Handbook for a copy of the Preventive Services Guide document.	No Charge	Deductible/Co-Insurance
	Routine Vision Exam	No Charge	Deductible/Co-Insurance
Physician and Practitioner Services	Primary Care Practitioner Home & Office Visits *Including Behavioral Health & Substance Abuse*	Deductible	Deductible/Co-Insurance
	Specialist Home & Office Visits	Deductible	Deductible/Co-Insurance
	Virtual Visits	Deductible	Not Covered
	Primary Care Practitioner Inpatient Visits	Deductible	Deductible/Co-Insurance
	Specialist Inpatient Visits	Deductible	Deductible/Co-Insurance
	All other outpatient services/procedures performed in a Practitioner's office not otherwise listed on this table	Deductible	Deductible/Co-Insurance
	Accidental Dental Services	Deductible	
	Maternity Care	Deductible	Deductible/Co-Insurance
	Chiropractic Office Visits & Manipulations	Deductible	Deductible/Co-Insurance
	Medications administered in the Practitioners office	Please refer to your Prescription Benefit Summary of Member Responsibility Table	
Chemotherapy Medication	Administered in the Practitioner's office, Outpatient Facility or in the home	Please refer to your Prescription Benefit Summary of Member Responsibility Table	
Diagnostic Services	X-Ray, Lab, Pathology Practitioners office or outpatient	Deductible	Deductible/Co-Insurance
	Diagnostic Mammography Services Practitioners office or outpatient	Deductible	Deductible/Co-Insurance
	PET Scans, MRIs, MRA's, CT Scans	Deductible	Deductible/Co-Insurance
	Stress Tests	Deductible	Deductible/Co-Insurance
	Ultrasounds/ Echocardiograms	Deductible	Deductible/Co-Insurance
Hospital Services	Inpatient Services *Including Behavioral Health & Substance Abuse*	Deductible	Deductible/Co-Insurance
	Outpatient Services or Procedures *Including Cardiac Rehabilitation, Radiation Therapy, Dialysis, Behavioral Health & Substance Abuse*	Deductible	Deductible/Co-Insurance
	Ambulatory Surgical Center	Deductible	Deductible/Co-Insurance
Rehabilitation Services	Therapy – Physical/Occupational/Speech	Deductible	Deductible/Co-Insurance
Home Health Care		Deductible	Deductible/Co-Insurance
Hospice Care		Deductible	Deductible/Co-Insurance
Durable Medical Equipment		Deductible	Deductible/Co-Insurance

Services	Benefits	Member Responsibility	
		In-Network	Out-of-Network
Medical Supplies	Including insulin pump supplies	Deductible	Deductible/Co-Insurance
Ambulance Services	Land and Air	Deductible	
Emergency/Urgent Care	Emergency Room Services	Deductible	
	Urgent Care	Deductible	Deductible/Co-Insurance
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 Benefit Summary of Member Responsibility Table		
Prescription Drugs:	Please see the Prescription Benefit Summary of Member Responsibility Table for prescription drug information, including medications administered in the Office or Outpatient setting.		

HSA ELIGILBE POS PLAN
SUMMARY OF MEMBER RESPONSIBILITY TABLE

This Summary reflects your member Out-Of-Pocket expenses.

Non-covered services and denied Benefits will not apply to your Out-Of-Pocket Limit.

IN-NETWORK:	
Annual Deductible:	**$3,000 per Member and $6,000 per Family each Benefit year**
Member's Co-Insurance:	**0% of Eligible Expenses, unless otherwise specified**
Out-Of-Pocket Limit:	**$3,000 per Member and $6,000 per Family each Benefit year**

Medical & pharmacy Co-Payments and Deductible will apply to the In-Network Out-Of-Pocket Limit when the services are provided by a Network Health Plan Participating Provider.

OUT-OF-NETWORK:	**Out-of-Network services for State Mandated benefits requiring Prior Authorization will have a 10% benefit reduction if the services are not Prior Authorized. Please refer to your Point of Service Plan Rider for a list of services that require prior authorization.**
Annual Deductible:	**$4,000 per Member and $8,000 per Family each Benefit year**
Member's Co-Insurance:	**20% of Eligible Expenses, unless otherwise specified**
Out-Of-Pocket Limit:	**$6,000 per Member and $12,000 per Family each Benefit year**

Out-Of-Pocket expenses incurred to satisfy Deductible and Co-Insurance will apply to the Out-of-Network Out-Of-Pocket Limit when the services are not provided by a Network Health Plan Participating Provider.

This is a summary of your health care coverage.

All Benefits are subject to the terms, limitations and exclusions of the Certificate of Coverage. Please refer to your Certificate of Coverage, Preventive Coverage or Preventive Services Guide, and any applicable Riders for detailed Benefits information, eligible services and coverage guidelines. Network Health Plan's coverage includes Benefits for all State of Wisconsin and Federal mandated benefits.

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	Please refer to your Member Handbook for a copy of the Preventive Services Guide document.	No Charge	Deductible/Co-Insurance
	Routine Vision Exam	No Charge	Deductible/Co-Insurance
Physician and Practitioner Services	Primary Care Practitioner Home & Office Visits *Including Behavioral Health & Substance Abuse*	Deductible	Deductible/Co-Insurance
	Specialist Home & Office Visits	Deductible	Deductible/Co-Insurance
	Virtual Visits	Deductible	Not Covered
	Primary Care Practitioner Inpatient Visits	Deductible	Deductible/Co-Insurance
	Specialist Inpatient Visits	Deductible	Deductible/Co-Insurance
	All other outpatient services/procedures performed in a Practitioner's office not otherwise listed on this table	Deductible	Deductible/Co-Insurance
	Accidental Dental Services	Deductible	
	Maternity Care	Deductible	Deductible/Co-Insurance
	Chiropractic Office Visits & Manipulations	Deductible	Deductible/Co-Insurance
	Medications administered in the Practitioners office	Please refer to your Prescription Benefit Summary of Member Responsibility Table	
Chemotherapy Medication	Administered in the Practitioner's office, Outpatient Facility or in the home	Please refer to your Prescription Benefit Summary of Member Responsibility Table	
Diagnostic Services	X-Ray, Lab, Pathology Practitioners office or outpatient	Deductible	Deductible/Co-Insurance
	Diagnostic Mammography Services Practitioners office or outpatient	Deductible	Deductible/Co-Insurance
	PET Scans, MRIs, MRA's, CT Scans	Deductible	Deductible/Co-Insurance
	Stress Tests	Deductible	Deductible/Co-Insurance
	Ultrasounds/ Echocardiograms	Deductible	Deductible/Co-Insurance
Hospital Services	Inpatient Services *Including Behavioral Health & Substance Abuse*	Deductible	Deductible/Co-Insurance
	Outpatient Services or Procedures *Including Cardiac Rehabilitation, Radiation Therapy, Dialysis, Behavioral Health & Substance Abuse*	Deductible	Deductible/Co-Insurance
	Ambulatory Surgical Center	Deductible	Deductible/Co-Insurance
Rehabilitation Services	Therapy – Physical/Occupational/Speech	Deductible	Deductible/Co-Insurance
Home Health Care		Deductible	Deductible/Co-Insurance
Hospice Care		Deductible	Deductible/Co-Insurance
Durable Medical Equipment		Deductible	Deductible/Co-Insurance

Services	Benefits	Member Responsibility	
		In-Network	Out-of-Network
Medical Supplies	Including insulin pump supplies	Deductible	Deductible/Co-Insurance
Ambulance Services	Land and Air	Deductible	
Emergency/Urgent Care	Emergency Room Services	Deductible	
	Urgent Care	Deductible	Deductible/Co-Insurance
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 Benefit Summary of Member Responsibility Table		
Prescription Drugs:	Please see the Prescription Benefit Summary of Member Responsibility Table for prescription drug information, including medications administered in the Office or Outpatient setting.		

100% HSA – POS
PRESCRIPTION BENEFIT SUMMARY OF MEMBER RESPONSIBILITY TABLE

NOTE: Upon reaching the out-of-pocket limit, prescription drugs, insulin, diabetic supplies, and specialty products will be covered at 100%.

Please refer to the Summary of Member Responsibility Table for annual deductible and out-of-pocket limit.

NOTE: Prescriptions dispensed through a non-participating pharmacy are not covered. All covered prescription dispensed through a participating pharmacy will apply to your annual IN PLAN deductible and out-of-pocket limit. Exception: Medications administered in a non-participating practitioner's office will apply to your annual OUT OF PLAN deductible and out-of-pocket limit.

PRESCRIPTION DRUGS, APPROVED CONTRACEPTIVES, INSULIN, AND DIABETIC SUPPLIES:	
a. Retail Pharmacy	Prescription drugs, insulin, and diabetic supplies prescribed by a NHP participating OR non-participating practitioner, and dispensed through a NHP participating retail pharmacy: Subject to deductible and out-of-pocket limit listed in the Summary of Member Responsibility Table Diabetic supplies refers to, for example, alcohol swabs/wipes, lancets, lancet devices, insulin syringes and needles, glucose monitors/meters, glucose control solutions, and blood and urine glucose and ketone test strips. All prescriptions, or refills, can be dispensed in quantities up to a 31 day supply. In addition: • Approved contraceptives including over the counter (OTC) products listed in the Preferred Drug List can be filled in quantities up to an 84 day supply at no cost. • Insulin and diabetic supplies can be filled in quantities up to a 91 day supply For insulin pump supplies, please refer to your medical supply benefit listed on your Summary of Member Responsibility Table.
b. Mail Order Pharmacy	Prescription drugs, insulin, and diabetic supplies prescribed by a NHP participating OR non-participating practitioner, and dispensed through a NHP participating mail order pharmacy in quantities up to a 91 day supply: Subject to deductible and out-of-pocket limit listed in the Summary of Member Responsibility Table NOTE: Preferred Specialty Products and Non-Preferred Specialty Products are not available through the mail order pharmacy.

	• Approved contraceptives including over the counter (OTC) products listed in the Preferred Drug List can be filled in quantities up to an 84 day supply at no cost.
SPECIALTY PRODUCTS:	
c. Specialty Pharmacy	Specialty Products prescribed by a NHP participating OR non-participating practitioner, and dispensed through a NHP participating specialty pharmacy in quantities up to a 31 day supply: Subject to deductible and out-of-pocket limit listed in the Summary of Member Responsibility Table
d. Practitioner's Office	Specialty Products prescribed by a NHP participating OR non-participating practitioner, and administered in a NHP participating OR non-participating practitioner's office: Subject to deductible and out-of-pocket limit listed in the Summary of Member Responsibility Table • Approved contraceptives administered in the office for contraceptive purposes are covered at no charge.

All benefits are subject to the terms, limitations and exclusions of the Certificate of Coverage. Please refer to your Certificate of Coverage, Preventive Coverage or Preventive Services Guide, and any applicable Riders for detailed benefits information, eligible services and coverage guidelines. Network Health Plan's coverage includes benefits for all State of Wisconsin and Federal mandated benefits.

Benefits for Non-Specialty injectable medications administered in a NHP participating practitioner OR non-participating practitioner's office are covered under the medical benefit and will follow the member responsibility outlined above in Section a. Retail Pharmacy.

If the practitioner indicates "Dispense As Written", or if the member requests the brand name product for a medication where a generic is available, the member must pay the applicable ancillary charge. The ancillary charge is the cost difference between the brand name product and the generic product up to a maximum of $200 per month's supply. The ancillary charge will not count towards the deductible or out-of-pocket limit. When generic substitution conflicts with state regulations or restrictions the pharmacist must gain approval from the prescriber to use the generic equivalent.

To receive a copy of the Network Health Plan Preferred Drug List, please call Customer Service at 1-800-826-0940, or visit www.networkhealth.com.