HSA ELIGIBLE HMO 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:	**$1,500 per Member and $3,000 per Family each Benefit year**
Member's Co-Insurance:	**0% of Eligible Expenses, unless otherwise specified**
Out-Of-Pocket Limit:	**$1,500 per Member and $3,000 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.

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.	