HSAPOS1011
H S A POS $3,000-90% PLAN
SUMMARY OF MEMBER RESPONSIBILITY TABLE

"A Health Savings Account Qualified Plan"

This Summary reflects your member out-of-pocket expenses. For Family coverage, benefits are not paid for any one Family member, until the entire Family deductible is met.

Out of pocket expenses incurred to satisfy deductible, coinsurance and copayments, apply toward the out of pocket limit. Costs of non-covered services, charges in excess of usual and customary amount and benefits reduced when prior authorization has not been obtained, will not apply toward the out of pocket limit.

IN PLAN:

Annual Deductible:	$3,000 Self only coverage and $6,000 Family coverage per year
Member's Coinsurance:	10% of Eligible Expenses, unless otherwise specified
Out-of-Pocket Limit:	$3,500 Self only coverage and $7,000 Family coverage per year

OUT OF PLAN:

Annual Deductible:	$4,000 Self only coverage and $8,000 Family coverage per year
Member's Coinsurance:	30% of Eligible Expenses, unless otherwise specified
Out-of-Pocket Limit:	$7,000 Self only coverage and $14,000 Family coverage per year

Maximum Policy Benefit:	$5,000,000 per Member, per Lifetime

All benefits are subject to the terms, limitations and exclusions of the Policy and Certificate of Coverage. Network Health Plan's coverage includes benefits for all state-mandated benefits. Please refer to your Certificate of Coverage and any applicable Riders for detailed benefit information, eligible services and coverage guidelines.

This summary describes your health care coverage in general terms. For a complete description of your health care coverage, restrictions, limitations and exclusions that apply to that coverage please contact Network Health Plan's Customer Service Department at 1-800-826-0940 or refer to your policy's Certificate of Coverage.

Services	Benefits	Member Responsibility	
		In-Plan	Out-of-Plan
Wellness/Preventive Health	Well Child Care Exams	No Charge	Deductible/Coinsurance
	Periodic Physical Exam	No Charge	Deductible/Coinsurance
	Immunizations	No Charge	Deductible/Coinsurance
	Mammography Services	No Charge	Deductible/Coinsurance
	Routine Eye Exams *(limited to one per 12 month period)*	Deductible/Coinsurance	Deductible/Coinsurance
Physician and Practitioner Services	**Primary Care Practitioner**		
	• Office and Home visits	Deductible/Coinsurance	Deductible/Coinsurance
	• Inpatient visits	Deductible/Coinsurance	Deductible/Coinsurance
	Specialty Physician		
	• Office and Home visits	Deductible/Coinsurance	Deductible/Coinsurance
	• Chiropractic office visits and manipulations	Deductible/Coinsurance	Deductible/Coinsurance
	• Allergy Immunizations	Deductible/Coinsurance	Deductible/Coinsurance
	• Accidental Dental Services	Deductible/Coinsurance	Deductible/Coinsurance
	• Radiation/Chemotherapy Services	Deductible/Coinsurance	Deductible/Coinsurance
	• Dialysis services	Deductible/Coinsurance	Deductible/Coinsurance
	• Surgery & Anesthesiology services	Deductible/Coinsurance	Deductible/Coinsurance
	• Routine Maternity (*pre & post natal care)*	Deductible/Coinsurance	Deductible/Coinsurance
	• Inpatient visits	Deductible/Coinsurance	Deductible/Coinsurance
	• Injectables administered in a Physician's office	*Please refer to your Prescription drug benefit levels.*	*Please refer to your Prescription drug benefit levels.*
Diagnostic Services	• X-Ray, Lab, Pathology *(practitioners office or outpatient)*	Deductible/Coinsurance	Deductible/Coinsurance
	• Diagnostic Mammography Services		
	• PET Scans, MRIs, MRA's, CT Scans ***No coverage if not prior authorized***	Deductible/Coinsurance	Deductible/Coinsurance
	• Stress Tests	Deductible/Coinsurance	Deductible/Coinsurance
	• Ultrasounds/ Echocardiogram	Deductible/Coinsurance	Deductible/Coinsurance
Hospital Services	• Inpatient Hospital ***No coverage if not prior authorized***	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
Ambulance Services	• Land and Air	Deductible/Coinsurance	Deductible/Coinsurance
Home Health Care	• Limited to 40 visits per 12 month period ***No coverage if not prior authorized***	Deductible/Coinsurance	Deductible/Coinsurance

Services	Benefits	Member Responsibility	
		In-Plan	Out-of-Plan
Hospice Care	***No coverage if not prior authorized***	Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equipment *(Prior authorization required for DME/Orthotics over $500 and prosthetics over $1,000. No coverage if not prior authorized.)*	• Prosthetics & Orthotics	Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Supplies	*Please refer to the Prescription Drug Summary of Member Responsibility Table.*		
Medical Supplies	*Including insulin pump supplies.*	Deductible/Coinsurance	Deductible/Coinsurance
Health Education Programs	Please refer to Certificate of Coverage for list of benefits & limitations	No Charge	Not Covered
Behavioral Health	Mental Health and Chemical Dependency Services • Inpatient–Limited to 10 days per year ***No coverage if not prior authorized*** • Transitional – Limited to 20 days per year • Outpatient – Limited to 20 visits per year	 Deductible/Coinsurance Deductible/Coinsurance Deductible/Coinsurance	 Deductible/Coinsurance Deductible/Coinsurance Deductible/Coinsurance
Emergency/Urgent Care *(Emergency room or hospital based urgent care facility)*	• Emergency Room Services	Deductible/Coinsurance	
	• Urgent Care	Deductible/Coinsurance	

NOTE: During regular office hours please call your PCP. The Time of day Hospital Urgent Care Service are available varies from facility to facility. Depending on the time of day and/or your condition, the facility may charge your services as Emergency Room. In this case, Emergency Room benefits will apply. If you need assistance in determining the urgency of a medical situation, call your Primary Care Practitioner's office or call Nurse Direct 24 hours a day, 7 days a week at 1-800-362-9900. Follow up emergency care must be directed by an NHP practitioner.

Prescription Drugs:	**Please see Prescription Coverage tab for prescription drug information.**