# HSA ELIGIBLE HMO 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:** | **$4,000 per Member and $8,000 per Family each Benefit Year** |
| **Member's Coinsurance:** | **20% of Eligible Expenses, unless otherwise specified** |
| **Out Of Pocket Limit:** | **$5,000 per Member and $10,000 per Family each Benefit Year** |

Applicable Medical & pharmacy Copayments, Deductible and Coinsurance may 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 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 Member Experience team at the number on the back of your ID card 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 | 0% Coinsurance per visit after Deductible |
| **Physician and Practitioner Services** | Primary Care Practitioner Home and Office Visits<br>*Including Behavioral Health, Substance Abuse and Telehealth* | 20% Coinsurance after Deductible |
| | FastCare® clinic visit<br>*Services must be provided at an approved, designated, clinic site as indicated.* | 0% Coinsurance per visit after Deductible |
| | Specialist Home and Office Visits<br>*Including Telehealth and Telemedicine* | 20% Coinsurance after Deductible |
| | Virtual Visits | 0% Coinsurance per visit after Deductible |
| | Primary Care Practitioner Inpatient Visits | 20% Coinsurance after Deductible |
| | Specialist Inpatient Visits | 20% Coinsurance after Deductible |
| | All other outpatient services/procedures performed in a Practitioner's office not otherwise listed on this table | 20% Coinsurance after Deductible |
| | Accidental Dental Services | 20% Coinsurance after Deductible |
| | Maternity Care | 20% Coinsurance after Deductible |
| | Chiropractic Office Visits and Manipulations | 20% Coinsurance after Deductible |
| **Infusion Services** | Administered in the Practitioner's office, Outpatient Facility or in the home | 20% Coinsurance after Deductible |
| **Diagnostic Services** | Lab and Pathology Practitioner's office or outpatient facility | 20% Coinsurance after Deductible |
| | Lab tests for condition management of chronic diseases | Deductible |
| | X-Ray and Diagnostic Imaging Practitioner's office or outpatient facility | 20% Coinsurance after Deductible |
| | PET Scans, MRIs, MRA's, CT Scans and Stress Tests | 20% Coinsurance after Deductible |
| | Ultrasounds/ Echocardiograms | 20% Coinsurance after Deductible |
| **Hospital Services** | Inpatient Services<br>*Including Behavioral Health and Substance Abuse* | 20% Coinsurance after Deductible |
| | Skilled Nursing Services | 20% Coinsurance after Deductible |
| | Outpatient Services or Procedures<br>*Including Cardiac Rehabilitation, Radiation Therapy, Dialysis, Behavioral Health and Substance Abuse* | 20% Coinsurance after Deductible |
| | Outpatient Surgery | 20% Coinsurance after Deductible |
| | Ambulatory Surgical Center | 15% Coinsurance after Deductible |
| **Rehabilitation Services** | Therapy –Physical/Occupational/Speech | 20% Coinsurance after Deductible |
| **Home Health Care** | | 20% Coinsurance after Deductible |

| Services | Benefits | Member Responsibility |
|---|---|---|
| **Hospice Care** | | 20% Coinsurance after Deductible |
| **Durable Medical Equipment** | | 20% Coinsurance after Deductible |
| **Medical Supplies** | Including insulin pump supplies | 20% Coinsurance after Deductible |
| **Ambulance Services** | Land and Air | 20% Coinsurance per transport after Deductible |
| **Emergency/Urgent Care** | Emergency Room Services | 20% Coinsurance after Deductible |
| | Urgent Care<br>*(Hospital based)* | 20% Coinsurance after Deductible |
| **Health Education Programs** | Please refer to the Certificate of Coverage for list of Benefits & limitations | No Charge |

| Prescription Drugs | Tier | Member Responsibility<br>In-Network |
|---|---|---|
| **Retail Pharmacy**<br><br>Prescription drugs, insulin, diabetic supplies, therapeutic vaccines, immunotherapy and chemotherapy prescribed by a practitioner and dispensed through a participating retail pharmacy or administered in the outpatient setting or home setting. | Tier 0 - Preventive Drugs | $0 Copayment per prescription or refill |
| | SmartChoice Drugs | $0 Copayment per prescription or refill after Deductible |
| | Tier 1 - Generic Drugs | $10 Copayment per prescription or refill after Deductible |
| | Tier 2 - Preferred Brand Drugs | $40 Copayment per prescription or refill after Deductible |
| | Tier 3 - Non Preferred Brand Drugs | 20% Coinsurance per prescription or refill after Deductible |
| | All prescriptions or refills can be dispensed in quantities up to a 90-day supply. Copayment required for each 30-day supply.<br><br>For insulin pump supplies, please refer to your medical supply benefit listed on your Medical SOMR | |
| | | |
| **Mail Order Pharmacy** | Tier 0 - Preventive Drugs | $0 Copayment per prescription or refill |
| | SmartChoice Drugs | $0 Copayment per prescription or refill after Deductible |
| | Tier 1 - Generic Drugs | $25 Copayment per prescription or refill after Deductible |
| | Tier 2 - Preferred Brand Drugs | $100 Copayment per prescription or refill after Deductible |
| | Tier 3 - Non Preferred Brand Drugs | 20% Coinsurance per prescription or refill after Deductible |
| | | |
| **Specialty Pharmacy** | Specialty Products (Tier 4) | 30% Coinsurance per prescription or refill after Deductible |
| | SaveonSP Specialty Products | Enrolled Members will have no cost share applied to these prescriptions. Non-enrolled Members will pay the entire Copayment for the drug which may be found at **networkhealth.com/saveon-drug-list** |
| | Specialty prescriptions or refills can be dispensed through a participating specialty pharmacy in quantities up to a 30-day supply. | |

**NOTE:** Covered prescription drugs as designated in the table above and dispensed through a Participating Pharmacy will apply to your Deductible and Out-of-Pocket Limit.

Please contact Network Health Plan's Member Experience team at the number on the back of your ID card for assistance in understanding your health care Benefits.
All benefits are subject to the terms, exclusions and limitations of the Certificate of Coverage Preventive Coverage or Preventive Services Guide and any applicable Riders. Network Health Plan's coverage includes benefits for all State of Wisconsin and Federally mandated benefits.

If the practitioner indicates "Dispense as Written," or if the Member requests the brand name product for a prescription Drug when a Network Health Plan approved generic is available, the Member must pay the applicable Copayment or Coinsurance plus the Ancillary Fee. The Ancillary Fee is the cost difference between the brand name product and the generic product up to a maximum of $200. When generic substitution conflicts with state regulations or restrictions, the pharmacists must gain approval from the prescribing Practitioner or use the generic equivalent. ACA Preventive Drugs may be exempt from the Ancillary Fee when a generic version has been tried, the Practitioner indicates the brand name product is medically necessary and prior approval for the $0 cost share has been approved.

Coverage for certain specialty pharmacy drugs that are considered non-essential health benefits are not subject to the out-of-pocket limits set under the Affordable Care Act. That means your cost share amount is not limited in the manner described in the tiers under this Rider, and the cost share amounts do not apply toward your out-of-pocket maximum. The SaveOn Program is a voluntary program. The SaveOn Program provides members who choose to enroll the opportunity to get certain specialty pharmacy drugs that are not covered as an essential health benefit at no additional out-of-pocket cost. If You are prescribed a drug covered under the SaveonSP program, You will be contacted to enroll in the program. If you choose to enroll in the SaveOn program, You will incur no cost for these drugs and the cost share will not be applied towards satisfying the Out-of-Pocket Limit. Members who decline to enroll will be responsible for the entire cost share, which will not be applied to the Out-of-Pocket Limit. A listing of the cost share amounts may be found at **networkhealth.com/saveon-drug-list**.

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To receive a copy of the Network Health Plan Preferred Drug List please call Member Experience at the number on the back of your ID card or visit **networkhealth.com**.