HSA ELIGIBLE 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.

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IN-NETWORK:	
Annual Deductible:	**$6,000 per Member and $12,000 per Family each Benefit Year**
Member's Coinsurance:	**20% of Eligible Expenses, unless otherwise specified**
Out Of Pocket Limit:	**$7,500 per Member and $15,000 per Family each Benefit Year**

Applicable Medical & Pharmacy Copayments, Deductible and Coinsurance may apply toward 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:	**$11,000 per Member and $22,000 per Family each Benefit Year**
Member's Coinsurance:	**40% of Eligible Expenses, unless otherwise specified**
Out Of Pocket Limit:	**$13,100 per Member and $26,200 per Family each Benefit Year**

Applicable Medical Copayments, Deductible and Coinsurance may apply toward the Out-of-Network Out-Of-Pocket Limit when 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 Services Guide, and any applicable Riders for detailed Benefits information, eligible services, and coverage guidelines. Network Health's coverage includes Benefits for all State of Wisconsin and Federal mandated benefits.

Please contact Network Health'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	
		In-Network	Out-of-Network
Preventive Health	Please refer to your Member Handbook for a copy of the Preventive Services Guide document.	No Charge	40% Coinsurance after Deductible
	Routine Vision Exam	No Charge	40% Coinsurance after Deductible
Physician and Practitioner Services	Primary Care Practitioner Home and Office Visits *Including Behavioral Health, Substance Abuse and Telehealth*	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	FastCare® clinic visit *Services must be provided at an approved, designated, clinic site as indicated in the rider.*	0% Coinsurance per visit after Deductible	Not Covered
	Specialist Home and Office Visits *Including Telehealth and Telemedicine*	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Virtual Visits	0% Coinsurance per visit after Deductible	Not Covered
	Primary Care Practitioner Inpatient Visits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Specialist Inpatient Visits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	All other outpatient services/procedures performed in a Practitioner's office not otherwise listed on this table	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Accidental Dental Services	20% Coinsurance after Deductible	
	Maternity Care	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Chiropractic Office Visits and Manipulations	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Infusion Services	Professional (Administration) Fees, facility charge, supplies and any other charges	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Services	Lab and Pathology Practitioner's office or outpatient	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Lab tests for condition management of chronic diseases	Deductible	40% Coinsurance after Deductible
	X-Ray and Diagnostic Imaging Practitioner's office or outpatient facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	PET Scans, MRIs, MRA's, CT Scans and Stress Tests	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Ultrasounds/ Echocardiograms	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Hospital Services	Inpatient Services *Including Behavioral Health and Substance Abuse*	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Skilled Nursing Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Services	Benefits	Member Responsibility	
		In-Network	Out-of-Network
	Outpatient Services or Procedures *Including Cardiac Rehabilitation, Radiation Therapy, Dialysis, Behavioral Health and Substance Abuse*	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Outpatient Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Ambulatory Surgical Center	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Rehabilitation Services	Therapy – Physical/Occupational/Speech	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Home Health Care		20% Coinsurance after Deductible	40% Coinsurance after Deductible
Hospice Care		20% Coinsurance after Deductible	40% Coinsurance after Deductible
Durable Medical Equipment		20% Coinsurance after Deductible	40% Coinsurance after Deductible
Medical Supplies	Including insulin pump supplies	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Ambulance Services	Land and Air	20% Coinsurance per transport after Deductible	
Emergency/Urgent Care	Emergency Room Services *Copayment waived if admitted inpatient within 24 hours*	20% Coinsurance after Deductible	
	Urgent Care *Hospital based*	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Health Education Programs	Please refer to the Certificate of Coverage for list of Benefits & limitations	No Charge	Not Covered

Prescription Drugs	Tier	Member Responsibility In-Network
Retail Pharmacy 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. 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
	Adherence Generics	$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**.