



**CITY OF MENASHA POS2\_C  
POINT OF SERVICE PLAN  
SUMMARY OF MEMBER RESPONSIBILITY TABLE**

**This Summary reflects your member copayments and other out-of-pocket expenses.**

Out-of-pocket expenses incurred to satisfy deductible and coinsurance, apply toward the In-Network out-of-pocket limit when the services are provided by a Network Health Plan Participating Provider.

Out-of-pocket expenses incurred when the services are not provided by a Network Health Plan Participating Provider will apply toward the out of network benefits.

The following will not apply towards the out-of-pocket limit: copayments, non-covered services, denied benefits, and the benefit reduction amount when prior authorization is not obtained.

<b>IN-NETWORK</b>	
<b>Annual Deductible:</b>	<b>\$250 per Member and \$500 per Family each Benefit year</b>
<b>Member's Coinsurance:</b>	<b>10% of Eligible Expenses, unless otherwise specified</b>
<b>Out-of-Pocket Limit:</b>	<b>\$500 per Member and \$1,000 per Family each Benefit year</b>

<b>OUT-OF-NETWORK:</b>	<b>Coverage for Out-of-Network services which require Prior Authorization as listed in your Point of Service Plan Rider will have a 10% benefit reduction if the services are not Prior Authorized.</b>
<b>Annual Deductible:</b>	<b>\$500 per Member and \$1,000 per Family each Benefit year</b>
<b>Member's Coinsurance:</b>	<b>30% of Eligible Expenses, unless otherwise specified</b>
<b>Out of Pocket Limit:</b>	<b>\$1,500 per Member and \$3,000 per Family each Benefit year</b>

<b>Maximum Policy Benefit:</b> In-Network & Out-of-Network benefits combined	<b>\$5,000,000 per Member per Lifetime</b>
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This is a summary of your health care coverage.

All benefits are subject to the terms of your policy. Please refer to your Certificate of Coverage and any applicable Riders for detailed benefit information, restrictions, limitations and exclusions that apply to that coverage.

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
<b>Preventive Health</b>	• Child Preventive Visit	No Charge	Deductible/Coinsurance
	• Adult Preventive Visit	No Charge	Deductible/Coinsurance
	• Immunizations	No Charge	Deductible/Coinsurance
	• Routine Mammography	No Charge	Deductible/Coinsurance
	• Routine Vision Exam	\$15 Copay per visit	Deductible/Coinsurance
<b>Physician and Practitioner Services</b>	• Primary Care Practitioner Home & Office Visits	\$15 Copay per visit	Deductible/Coinsurance
	• Specialist Home & Office Visits	\$15 Copay per visit	Deductible/Coinsurance
	• Primary Care Practitioner Inpatient Visits	No Charge	Deductible/Coinsurance
	• Specialist Inpatient Visits	No Charge	Deductible/Coinsurance
	• Allergy Immunizations	No Charge	Deductible/Coinsurance
	• Accidental Dental Services	No Charge	No Charge
	• Radiation/Chemotherapy Services	No Charge	Deductible/Coinsurance
	• Dialysis Services	No Charge	Deductible/Coinsurance
	• Surgery & Anesthesiology Services	No Charge	Deductible/Coinsurance
	• Maternity Care	No Charge	Deductible/Coinsurance
	• Chiropractic Office Visits & Manipulations	\$15 Copay per visit	Deductible/Coinsurance
	• Medications Administered in a Physician's Office	Please refer to your Prescription Drug Rider	
	<b>Diagnostic Services</b>	• X-Ray, Lab, Pathology Practitioners office or outpatient	No Charge
• Diagnostic Mammography Services Practitioners office or outpatient		No Charge	Deductible/Coinsurance
• PET Scans, MRIs, MRA's, CT Scans		No Charge	Deductible/Coinsurance
• Stress Tests		No Charge	Deductible/Coinsurance
• Ultrasounds/ Echocardiograms		No Charge	Deductible/Coinsurance
<b>Hospital Services</b>	• Inpatient Hospital	Deductible/Coinsurance	Deductible/Coinsurance
	• Outpatient Services or Procedures Including Cardiac Rehabilitation	Deductible/Coinsurance	Deductible/Coinsurance
	• Ambulatory Surgical Center	Deductible/Coinsurance	Deductible/Coinsurance
<b>Rehabilitation Services</b>	• Therapy – Physical/Occupational/Speech	\$15 Copay per visit	Deductible/Coinsurance
<b>Home Health Care</b>		No Charge	Deductible/Coinsurance

Services	Benefits	Member Responsibility	
		In-Network	Out-of-Network
<b>Hospice Care</b>		No Charge	Deductible/Coinsurance
<b>Durable Medical Equipment</b>		Deductible/Coinsurance	Deductible/Coinsurance
<b>Medical Supplies</b>	Including insulin pump supplies	No Charge	Deductible/Coinsurance
<b>Behavioral Health</b> Mental Health & Chemical Dependency Services	• Inpatient Limited to 10 days per Benefit year	No Charge	Deductible/Coinsurance
	• Transitional Limited to 20 days per Benefit year	No Charge	Deductible/Coinsurance
	• Outpatient Limited to 20 days per Benefit year	No Charge	Deductible/Coinsurance
<b>Ambulance Services</b>	• Land and Air	No Charge	
<b>Emergency/Urgent Care</b>	• Emergency Room Services	\$50 Copay per visit	
	• Urgent Care	\$15 Copay per visit	Deductible/Coinsurance
<b>Health Education Programs</b>	Please refer to the Certificate of Coverage for list of benefits & limitations	No Charge	Not Covered
<b>Diabetic Supplies</b>	Please refer to the Prescription Summary of Member Responsibility Table		
<b>Prescription Drugs:</b>	Please see the Prescription Summary of Member Responsibility Table for prescription drug information, including medications administered in the Office or Outpatient setting.		