



## HMO COCHOICE 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.

<b>IN-NETWORK:</b>	
<b>Annual Deductible:</b>	<b>\$1,000 per Member and \$2,000 per Family each Benefit year</b>
<b>Member's Co-Insurance:</b>	<b>0% of Eligible Expenses, unless otherwise specified</b>
<b>Out-Of-Pocket Limit:</b>	<b>\$3,000 per Member and \$6,000 per Family each Benefit year</b>
Applicable Medical & pharmacy Co-Payments, Deductible and Co-Insurance 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 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.

<b>Services</b>	<b>Benefits</b>	<b>Member Responsibility</b>
<b>Preventive Health</b>	Please refer to your Member Handbook for a copy of the Preventive Services Guide document.	No Charge
	Routine Vision Exam	No Charge
<b>Physician and Practitioner Services</b>	Primary Care Practitioner Home & Office Visits <i>Including Behavioral Health &amp; Substance Abuse</i>	\$15 Co-Pay per visit
	Specialist Home & Office Visits	\$50 Co-Pay per visit
	Virtual Visits	\$10 Co-Pay per visit
	Primary Care Practitioner Inpatient Visits	No Charge
	Specialist Inpatient Visits	No Charge
	All other outpatient services/procedures performed in a Practitioner's office not otherwise listed on this table	No Charge
	Accidental Dental Services	\$50 Co-Pay per visit
	Maternity Care	No Charge
	Chiropractic Office Visits & Manipulations	\$15 Co-Pay per visit
	Medications administered in the Practitioner's office	Please refer to your Prescription Benefit Summary of Member Responsibility Table
	Administered in the Practitioner's office, Outpatient Facility or in the home	Please refer to your Prescription Benefit Summary of Member Responsibility Table
<b>Chemotherapy Medication</b>	Lab, Pathology Practitioner's office or outpatient	No Charge
	X-Ray and Diagnostic Imaging Practitioner's office or outpatient	No Charge
	PET Scans, MRIs, MRA's, CT Scans	No Charge
	Stress Tests	No Charge
	Ultrasounds/ Echocardiograms	No Charge
<b>Hospital Services</b>	Inpatient Services <i>Including Behavioral Health &amp; Substance Abuse</i>	Deductible
	Outpatient Services or Procedures <i>Including Cardiac Rehabilitation, Radiation Therapy, Dialysis, Behavioral Health &amp; Substance Abuse</i>	Deductible
	Ambulatory Surgical Center	Deductible
<b>Rehabilitation Services</b>	Therapy – Physical/Occupational/Speech	Deductible
<b>Home Health Care</b>		Deductible

Services	Benefits	Member Responsibility
<b>Infusion Services</b>	Pharmacy charge for medication (See Pharmacy Summary of Member Responsibility)	Based on formulary and benefit for tier
	Professional (Administration) Fees, facility charge, supplies and any other charges	Deductible
<b>Hospice Care</b>		No Charge
<b>Durable Medical Equipment</b>		Deductible
<b>Medical Supplies</b>	Including insulin pump supplies	Deductible
<b>Ambulance Services</b>	Land and Air	\$200 Co-pay per transport
<b>Emergency/ Urgent Care</b>	Emergency Room Services (Co-Pay waived if admitted inpatient within 24 hours)	\$250 Co-Pay per visit
	Urgent Care (Hospital based)	\$75 Co-Pay per visit
<b>Health Education Programs</b>	Please refer to Certificate of Coverage for list of Benefits & limitations	No Charge
<b>Diabetic Supplies</b>	Please refer to the Prescription Benefit Summary of Member Responsibility Table	
<b>Prescription Drugs:</b>	Please see the Prescription Benefit Summary of Member Responsibility Table for prescription drug information, including medications administered in the Office or Outpatient setting.	







**\$10/\$30/\$60**

**PRESCRIPTION BENEFIT SUMMARY OF MEMBER RESPONSIBILITY (SOMR)**

This Summary reflects the Member Copayments and other Out-of-Pocket expenses for Prescription Drugs, Insulin, Diabetic Supplies, Contraceptives, Specialty Products, Therapeutic Vaccines, Chemotherapy, and Immunotherapy.

Please refer to the Medical SOMR for annual Out-of-Pocket Limit.

**NOTE: Ancillary Fee will apply towards your Out-of-Pocket Limit. Upon reaching the Out-of-Pocket Limit Prescription Drugs, Insulin, Diabetic Supplies, Contraceptives, Specialty Products, Therapeutic vaccines, Chemotherapy, and Immunotherapy will be covered at 100%.**

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

<b>PRESCRIPTION DRUGS, CONTRACEPTIVES, INSULIN, AND DIABETIC SUPPLIES:</b>	
<b>Retail Pharmacy</b> or administered in the practitioner's office, outpatient facility, or in the home as indicated in your Medical SOMR	<p>Prescription drugs, contraceptives, 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 as indicated in your Medical SOMR:</p> <p>Tier 0      \$0 Copayment per prescription or refill</p> <p>Tier 1      \$10 Copayment per prescription or refill</p> <p>Tier 2      \$30 Copayment per prescription or refill</p> <p>Tier 3      \$60 Copayment per prescription or refill</p> <p>Diabetic Supplies:</p> <p>Tier 1      \$10 Copayment per prescription or refill</p> <p>Tier 2      \$30 Copayment per prescription or refill</p> <p>Tier 3      \$60 Copayment per prescription or refill</p>
<b>Retail Pharmacy</b> (continued)	<p>Diabetic supplies refer to, for example, alcohol swabs/wipes, lancets, lancet devices, insulin syringes and needles, glucose monitors/meters, glucose control solutions, and blood and urine glucose and ketone test strips.</p> <ul style="list-style-type: none"> <li>All prescriptions, or refills, can be dispensed in quantities up to a 90-day supply. Copay required for each 30-day supply. Contraceptives administered in the office for contraceptive purposes are covered at no cost.</li> </ul> <p>For insulin pump supplies, please refer to your medical supply benefit listed on your Medical SOMR.</p>

**Prescription Coverage**

<p><b>Mail Order Pharmacy</b></p>	<p>Prescription drugs, contraceptives, insulin, diabetic supplies, therapeutic vaccines, immunotherapy, and chemotherapy prescribed by a practitioner and dispensed through a participating mail order pharmacy in quantities up to a 90-day supply:</p> <p>Tier 0            \$0 Copayment per prescription or refill</p> <p>Tier 1            \$25 Copayment per prescription or refill</p> <p>Tier 2            \$75 Copayment per prescription or refill</p> <p>Tier 3            \$150 Copayment per prescription or refill</p> <p>Diabetic Supplies:</p> <p>Tier 1            \$25 Copayment per prescription or refill</p> <p>Tier 2            \$75 Copayment per prescription or refill</p> <p>Tier 3            \$150 Copayment per prescription or refill</p> <p>NOTE: Preferred Specialty Products and Non-Preferred Specialty Products are not available through the mail order pharmacy. Contraceptives including over the counter (OTC) products listed in the Preferred Drug List can be filled in quantities up to an 84-day supply at no cost.</p>
<p><b>SPECIALTY PRODUCTS:</b></p>	
<p><b>Specialty Pharmacy</b> or administered in the practitioner's office, outpatient facility, or in the home as indicated in your Medical SOMR</p>	<p>Specialty Products, immunotherapy, and chemotherapy prescribed by a practitioner and dispensed through a participating specialty pharmacy, or administered in the outpatient setting, or home setting as indicated in your Medical SOMR:</p> <p>Preferred Specialty Products    \$30 Copayment per prescription or refill (Tier 2)</p> <p>Non-Preferred Specialty Products (Tier 3)            \$60 Copayment per prescription or refill</p> <ul style="list-style-type: none"> <li>Specialty prescriptions, or refills, can be dispensed through a participating specialty pharmacy in quantities up to a 30-day supply.</li> </ul>

All benefits are subject to the terms, exclusions and limitations of the Certificate of Coverage. Network Health Plan's coverage includes benefits for all State of Wisconsin and Federal mandated benefits.

If the practitioner indicates "Dispense as Written", or if the member requests the brand name product for a medication where a generic is available, the member must pay the applicable Copayment 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 per month's supply. The ancillary charge will count towards the combined medical and pharmacy Out-of-Pocket Limit. When generic substitution conflicts with state regulations or restrictions the pharmacist must gain approval from the prescriber to use the generic equivalent.

To receive a copy of the Network Health Plan Preferred Drug List, please call Customer Service at 1-800-826-0940, or visit [www.networkhealth.com](http://www.networkhealth.com).

HMO plans underwritten by Network Health Plan.  
POS plans underwritten by Network Health Insurance Corporation or Network Health Insurance Corporation and Network Health Plan.

# Network Health

## PRESCRIPTION DRUG (RX) RIDER

It is understood and agreed that prescription drug benefits shall be defined and provided under the Network Health Certificate of Coverage (COC) in accordance with the terms and conditions of this Rider, as set forth below:

- I. **ELIGIBILITY:** All Members are eligible for covered prescription drug benefits under the terms and conditions of this Rider.
  
- II. **COVERED SERVICES:** Covered prescription drug benefits provided under this Rider include Food and Drug Administration (FDA) approved prescription drugs dispensed under the guidelines in Network Health's Preferred Drug List (PDL), and Specialty Products Designation as applicable, and are:
  - A. Dispensed pursuant to the prescription of an appropriately licensed Participating or Authorized Practitioner;
  - B. Prescription drugs not designated as Specialty Products filled at or administered by a Participating Pharmacy, Practitioner's office, home infusion, in the home, infusion center, outpatient facility, or through a Participating Mail Order Pharmacy Program that is appropriately licensed to dispense prescription drugs in the United States by the Federal Drug Enforcement Agency and the State;
  - C. Designated as a Specialty Product and dispensed at a Participating Specialty Pharmacy or administered by a Practitioner's office, home infusion, in the home, infusion center, or outpatient facility;
  - D. Received in full compliance with Article III-Obtaining Health Services of the COC;
  - E. Medically Necessary and appropriate.
  
- III. **PAYMENT:** Prescription drugs, including Specialty Products which are subject to a Member Copayment and or Coinsurance and or Deductible and or Out-of-Pocket as specified in your Summary of Member Responsibility (SOMR) document and the PDL, shall be covered under this Rider.
  
- IV. **LIMITATIONS:** Prescription drug benefits covered under this Rider are subject to the following limitations:
  - A. Initial prescriptions or prescription refills obtained from a Participating Retail Pharmacy, Participating Specialty Pharmacy, or Participating Mail Order Pharmacy will be covered up



to the limits outlined in your SOMR document and the PDL in accordance with directions from the prescribing Practitioner;

- B. If the practitioner indicates “Dispense as Written”, or if the member requests the brand name product for a prescription drug when an Network Health approved generic is available, the member must pay the applicable Copayment and 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 per month’s supply. The ancillary charge will count towards the combined medical and pharmacy Deductible and or Out-of-Pocket Limit. When generic substitution conflicts with state regulations or restrictions the pharmacist must gain approval from the prescribing practitioner to use the generic equivalent.
- C. Prescription refills are covered only after seventy-five percent (75%) of the previously dispensed amount is used;
- D. In Emergency conditions, prescription drugs may be prescribed by a Non-Participating Practitioner and dispensed through a Non-Participating Pharmacy; You may be required to pay the difference between what you pay for the prescription drug at the Non-Participating Pharmacy and the cost that we would cover at a Participating Pharmacy.
- E. HIV treatment prescription drugs will be covered if they are:
  - (a) Prescribed by a Participating Practitioner and, either
  - (b) Approved by the FDA; or
  - (c) In or have completed Phase 3 of the FDA’s clinical evaluation and are administered under a protocol approved by the FDA.
- F. Certain prescription drugs (agents, medications, components) are determined and listed by Network Health’s Pharmacy and Therapeutics (P&T) Committee to have an increased potential for improper use, misuse, or abuse. These prescription drugs require Prior Authorization by Network Health. A listing of the prescription drugs is provided to Network Health Practitioners. Members can access the listing of prescription drugs on the Network Health website. Prior Authorization must be requested by the Member or their treating Practitioner before the prescription drugs will be considered covered under this Prescription Drug Rider. Prescription drugs may be removed from the list and other prescription drugs may be added at any time based on the decisions of the P&T Committee;
- G. Prescription drugs categorized as self-administered injectables may be authorized for a one-month teaching dose in a participating prescriber’s office. Future fills may be required to be obtained at a participating pharmacy.
- H. Products designated as Specialty Products on Network Health’s PDL will be covered subject to the terms and limitations specified in your SOMR document and the PDL.
- I. Prescription drugs given during a hospital or outpatient visit will be an Eligible Expense under the inpatient or outpatient benefit.



V. **EXCLUSIONS:** The following prescription drug benefits will not be covered under the COC or this Rider.

- A. Over-the-counter drugs and supplies with or without a prescription, unless specifically listed in the most recent edition of the PDL; prescription drug products that are comprised of components that are available in over-the-counter form or equivalent unless specifically listed in the most recent edition of the PDL; Certain prescription drug products that we have determined are therapeutically equivalent to an over-the-counter drug;
- B. Prescription drugs prescribed for treatment of Infertility, unless otherwise provided by a valid Rider to the COC;
- C. Experimental or other FDA approved prescription drugs including compounded prescription drugs which are to be used for experimental purposes or unapproved routes of administration, except for HIV treatment prescription drugs that are;
  - (a) Prescribed by a Participating Practitioner and, either
  - (b) Approved by the FDA; or
  - (c) In or have completed Phase 3 of the FDA's clinical evaluation and are administered under a protocol approved by the FDA.
- D. Prescriptions or refill prescriptions required by a Member because of theft, damage, or loss of the prescription;
- E. Prescriptions or refills exceeding dispensing limitations, for vacation, travel, or other periods of extended duration, unless Prior Authorized by Network Health;
- F. Take-home prescription drugs are not covered if dispensed prior to your release from confinement from Home Health Care Services, Inpatient Services, Skilled Nursing Facility, or dispensed from a Practitioner's Office. This does not apply to prescription drugs a Member receives while an inpatient, as part of an Authorized Home Health Care Program, while a resident in a Skilled Nursing Facility, or to Non-Specialty Products if administered in the Practitioner's office.
- G. Prescription drug products dispensed outside the United States, except as required for Emergency treatment;
- H. Prescription drug products furnished by the local, state, or federal government. Any prescription drug product to the extent payment or benefits are provided or available for the local, state, or federal government (for example, Medicare) if payment or benefits are received, except as otherwise provided by law;
- I. Prescription drug products for any condition, injury, sickness, or mental illness arising out of, or while, employment for which benefits are available under any workers' compensation law or other similar laws, if a claim for such benefits is made or payment or benefits are received;
- J. Any product dispensed for appetite suppression or weight loss.
- K. Durable Medical Equipment prescribed and non-prescribed outpatient supplies, other than items specifically stated as covered in the PDL;

- L. General vitamins, except the following which require a prescription and are not available in a therapeutically equivalent over-the-counter formulation: prescription prenatal vitamins, vitamins with fluoride, and single entity vitamins;
- M. Unit dose packaging of prescription drug products;
- N. Prescription drug products used for cosmetic purposes;
- O. Prescription drug products, including new prescription drug products or new dosage forms, that we determine do not meet the definition of a Covered Service;
- P. Compounded drugs that do not contain at least one ingredient that has been approved by the FDA, and not otherwise excluded from coverage by Network Health as experimental, and requires a prescription order; Compounded drugs that are available as a similar commercially available prescription drug product;
- Q. Bulk Powders
- R. Repackagers
- S. New prescription drug products and or new dosage forms until the date they are assigned to a tier by the P&T Committee.
- T. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- U. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease including prescription medicinal food products, even when used for the treatment of sickness or injury.
- V. A prescription drug product that contains (an) active ingredient(s) available as another therapeutically equivalent or modified version of a covered prescription drug product. Such determinations may be made by the P&T Committee. We may decide at any time to reinstate Benefits for a prescription drug product that was previously excluded under this provision.
- W. Prescription drug products that have not undergone current FDA approval process may not be covered as determined by the P&T Committee. These prescription drugs may also be known as Non-FDA approved drugs or DESI drugs (Drug Efficacy Study Implementation).
- X. Prescription drugs for sexual dysfunctions.

**VI. INTERPRETATIONS OF CERTIFICATE:** Except as expressly provided above by this Rider, or by other Riders which shall be made part of the COC, the terms and conditions of the COC control and remain the same and are in full force and effect.

## **VII. DEFINITIONS**

**SPECIALTY PRODUCT:** Network Health's P&T Committee may designate pharmaceutical products as Preferred Specialty Products and Non-Preferred Specialty Products. These products will be covered as Tier 2 and 3, respectively on your SOMR document and the PDL. Designation will be based on method of administration and/or cost. Pharmaceutical products that have been designated as Specialty Products will be indicated on Network Health's PDL.

**OVER-THE-COUNTER DRUGS:** An over-the-counter drug is a drug that is not a prescription drug, or a drug whose ingredient(s) are available without a prescription.

**PARTICIPATING RETAIL PHARMACY, PARTICIPATING MAIL ORDER PHARMACY, AND PARTICIPATING SPECIALTY PHARMACY:** A pharmacy that has a contract to provide benefits to you or your covered dependents under this Rider.

**PREVENTIVE DRUGS:** Prescription drugs that are used for the prevention of certain medical conditions.

**SELF-ADMINISTERED INJECTABLE:** An injectable prescription drug that can be administered in a home setting.

**TIER 0 DRUGS:** Preventive Drugs

**TIER 1 DRUGS:** Prescription drugs consisting of generic prescription drugs based on their effectiveness and cost.

**TIER 2 DRUGS:** Prescription drugs consisting of brand name prescription drugs and preferred specialty prescription drugs based on their effectiveness and cost.

**TIER 3 DRUGS:** Prescription drugs consisting of non-preferred prescription drugs and non-preferred specialty prescription drugs based on their effectiveness and cost.



