



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.summacare.com](http://www.summacare.com) or call 800.996.8701. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 800.996.8701 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                         | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | For <a href="#">network providers</a><br>\$100 individual / \$200 family                                                                                                                        | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive</a> care, primary care visits, diabetic eye exams, pediatric vision exam and frames and generic drugs are covered before you meet your <a href="#">deductible</a> . | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No                                                                                                                                                                                              | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For <a href="#">network providers</a><br>\$1,550 individual / \$3,100 family                                                                                                                    | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance billing</a> charges and health care this <a href="#">plan</a> doesn't cover.                                                                     | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.summacare.com/providersearch">www.summacare.com/providersearch</a> or call 800.996.8701 for a list of <a href="#">network providers</a> .                          | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.                                                                                                                                                                                             | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event                                                   | Services You May Need                                  | What You Will Pay                                                                                                                       |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                    |
|------------------------------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                        |                                                        | Network Provider<br>(You will pay the least)                                                                                            | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                           |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness       | \$0 <a href="#">copay</a> for first three visits, then \$10 <a href="#">copay</a> per visit. <a href="#">Deductible</a> does not apply. | Not covered                                        | None                                                                                                                                                                                                                                                                      |
|                                                                        | <a href="#">Specialist</a> visit                       | 10% <a href="#">coinsurance</a> per visit                                                                                               | Not covered                                        | <a href="#">Prior authorization</a> is required to see a surgeon for back pain. Obtaining <a href="#">prior authorization</a> is provider's responsibility for in-network services. Failure to obtain <a href="#">prior authorization</a> will result in denial of claim. |
|                                                                        | <a href="#">Preventive care/screening/immunization</a> | No charge                                                                                                                               | Not covered                                        | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.                                               |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 10% <a href="#">coinsurance</a>                                                                                                         | Not covered                                        | Physician order required.                                                                                                                                                                                                                                                 |
|                                                                        | Imaging (CT/PET scans, MRIs)                           | 10% <a href="#">coinsurance</a>                                                                                                         | Not covered                                        | Requires <a href="#">prior authorization</a> . Obtaining <a href="#">prior authorization</a> is provider's responsibility for in-network services. Failure to obtain <a href="#">prior authorization</a> will result in denial of claim.                                  |

| Common Medical Event                                                                                                                                                                                                                                                          | Services You May Need           | What You Will Pay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                               |                                 | Network Provider<br>(You will pay the least)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <p><b>If you need drugs to treat your illness or condition</b><br/>More information about <a href="http://www.summacare.com/formulary">prescription drug coverage</a> is available at <a href="http://www.summacare.com/formulary">http://www.summacare.com/formulary</a></p> | Generic drugs                   | <p>\$5/\$15 <a href="#">copay</a> per prescription (<a href="#">Deductible</a> does not apply) for preferred/non-preferred generic drugs for up to a 30-day supply retail.</p> <p>\$15/\$45 <a href="#">copay</a> per prescription (<a href="#">Deductible</a> does not apply) for preferred/non-preferred generic drugs for up to a 90-day supply retail.</p> <p>\$10/\$30 <a href="#">copay</a> per prescription (<a href="#">Deductible</a> does not apply) for preferred/non-preferred generic drugs through our mail order pharmacy.</p> | Not covered                                        | <p>Brand and generic drugs limited to a 90-day supply at retail. Brand and generic drugs up to a 90-day supply through mail order. \$100 maximum for up to a 30-day supply of Brand Orally Administered Cancer Drugs. Some drugs require <a href="#">prior authorization</a>. Refer to our <a href="http://www.summacare.com/formulary">formulary</a>, <a href="http://www.summacare.com/formulary">http://www.summacare.com/formulary</a>. Mail Order is covered through our Contracted Mail Order Pharmacy.</p> |
|                                                                                                                                                                                                                                                                               | Preferred brand drugs           | 40% <a href="#">coinsurance</a> per prescription for up to a 30-day or 90-day supply retail or through our mail order pharmacy.                                                                                                                                                                                                                                                                                                                                                                                                               | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                               | Non-preferred brand drugs       | 45% <a href="#">coinsurance</a> per prescription for up to a 30-day or 90-day supply retail or through our mail order pharmacy.                                                                                                                                                                                                                                                                                                                                                                                                               | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                               | <a href="#">Specialty drugs</a> | 50% <a href="#">coinsurance</a> per prescription for up to a 30-day supply retail.                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Not covered                                        | <p>Limited up to a 30-day supply (retail prescription). Some drugs require <a href="#">prior authorization</a>. Refer to our <a href="http://www.summacare.com/formulary">formulary</a>, <a href="http://www.summacare.com/formulary">http://www.summacare.com/formulary</a>.</p>                                                                                                                                                                                                                                 |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                                                                       |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Network Provider<br>(You will pay the least)                                                                                            | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                     |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | 10% <a href="#">coinsurance</a>                                                                                                         | Not covered                                        | Certain outpatient services require <a href="#">prior authorization</a> . Refer to <a href="#">prior authorization</a> list at <a href="http://www.summacare.com">www.summacare.com</a> . Obtaining <a href="#">prior authorization</a> is provider's responsibility for in-network services. Failure to obtain <a href="#">prior authorization</a> will result in denial of claim. |
|                                                                           | Physician/surgeon fees                           | 10% <a href="#">coinsurance</a>                                                                                                         | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 10% <a href="#">coinsurance</a>                                                                                                         | 10% <a href="#">coinsurance</a>                    | Out-of-network subject to <a href="#">balance billing</a> .                                                                                                                                                                                                                                                                                                                         |
|                                                                           | <a href="#">Emergency medical transportation</a> | 10% <a href="#">coinsurance</a>                                                                                                         | 10% <a href="#">coinsurance</a>                    | Out-of-network subject to maximum allowable charge.                                                                                                                                                                                                                                                                                                                                 |
|                                                                           | <a href="#">Urgent care</a>                      | 10% <a href="#">coinsurance</a>                                                                                                         | 10% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                                                                                                                |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 10% <a href="#">coinsurance</a>                                                                                                         | Not covered                                        | Requires <a href="#">prior authorization</a> . Obtaining <a href="#">prior authorization</a> is provider's responsibility for in-network services. Failure to obtain <a href="#">prior authorization</a> will result in denial of claim.                                                                                                                                            |
|                                                                           | Physician/surgeon fees                           | 10% <a href="#">coinsurance</a>                                                                                                         | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$0 <a href="#">copay</a> for first three visits, then \$10 <a href="#">copay</a> per visit. <a href="#">Deductible</a> does not apply. | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                           | Inpatient services                               | 10% <a href="#">coinsurance</a>                                                                                                         | Not covered                                        | Requires <a href="#">prior authorization</a> . Obtaining <a href="#">prior authorization</a> is provider's responsibility for in-network services. Failure to obtain <a href="#">prior authorization</a> will result in denial of claim.                                                                                                                                            |
| If you are pregnant                                                       | Office visits                                    | \$10 <a href="#">copay</a> for initial visit, then \$0 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.               | Not covered                                        | Maternity care may include tests and services described elsewhere in the Summary of Benefits and Coverage (i.e. ultrasound).                                                                                                                                                                                                                                                        |
|                                                                           | Childbirth/delivery professional services        | 10% <a href="#">coinsurance</a>                                                                                                         | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                           | Childbirth/delivery facility services            | 10% <a href="#">coinsurance</a>                                                                                                         | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                     |

| Common Medical Event                                                  | Services You May Need                     | What You Will Pay                                                                                                                                                                                                                                                                                   |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                   |
|-----------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                           | Network Provider<br>(You will pay the least)                                                                                                                                                                                                                                                        | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                          |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | 10% <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                     | Not covered                                        | 100 visits per calendar year                                                                                                                                                                                                             |
|                                                                       | <a href="#">Rehabilitation services</a>   | \$10 <a href="#">copay</a> per physical therapy or occupational therapy visit. <a href="#">Deductible</a> does not apply<br>10% <a href="#">coinsurance</a> for all other rehabilitation services                                                                                                   | Not covered                                        | Physical Therapy, Occupational Therapy, Speech Therapy and Pulmonary Rehabilitation limited to 20 visits/calendar year each; Cardiac Rehabilitation limited to 36 visits/calendar year.                                                  |
|                                                                       | <a href="#">Habilitation services</a>     | \$10 <a href="#">copay</a> per physical therapy or occupational therapy visit. <a href="#">Deductible</a> does not apply<br>10% <a href="#">coinsurance</a> for all other rehabilitation services<br>\$10 <a href="#">copay</a> per mental health visit. <a href="#">Deductible</a> does not apply. | Not covered                                        | 20 visits per service, includes Physical Therapy, Speech Therapy and Occupational Therapy; 30 visits per year for Mental/Behavioral Health Outpatient Services; 20 hours per week for Clinical Therapeutic Intervention.                 |
|                                                                       | <a href="#">Skilled nursing care</a>      | 10% <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                     | Not covered                                        | 90 days per calendar year                                                                                                                                                                                                                |
|                                                                       | <a href="#">Durable medical equipment</a> | 10% <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                     | Not covered                                        | Requires <a href="#">prior authorization</a> . Obtaining <a href="#">prior authorization</a> is provider's responsibility for in-network services. Failure to obtain <a href="#">prior authorization</a> will result in denial of claim. |
|                                                                       | <a href="#">Hospice services</a>          | 10% <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                     | Not covered                                        | None                                                                                                                                                                                                                                     |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | No charge                                                                                                                                                                                                                                                                                           | Not covered                                        | One routine exam every 12 months.                                                                                                                                                                                                        |
|                                                                       | Children's glasses                        | No charge                                                                                                                                                                                                                                                                                           | Not covered                                        | One frame/set of lenses every 12 months.                                                                                                                                                                                                 |
|                                                                       | Children's dental check-up                | Not covered                                                                                                                                                                                                                                                                                         | Not covered                                        | Routine fluoride dental exam for a child covered under <a href="#">preventive</a> benefit at no charge in-network.                                                                                                                       |

#### Excluded Services & Other Covered Services:

**Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)**

- |                                                                                                                                              |                                                                                                                                                           |                                                                                                                                                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Abortion</li> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care</li> <li>• Infertility treatment. Initial testing covered only.</li> <li>• Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- |                                                                                                                     |                                                                         |                                                                                                        |
|---------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Hearing aids (ages 21 and younger)</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility testing</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Teladoc visits</li> </ul> |
|---------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877.267.2323 x61565 or [www.cms.gov/ccio/index.html](http://www.cms.gov/ccio/index.html). Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 800.318.2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the plan at 800.996.8701 or the Ohio Department of Insurance's Consumer Hotline at 800.686.1526 or [www.insurance.ohio.gov](http://www.insurance.ohio.gov).

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

#### **Language Access Services:**

[Spanish (Español): Para obtener asistencia en Español, llame al 800.996.8701.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800.996.8701.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 800.996.8701.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 800.996.8701.]

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number.

The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$100 |
| ■ <a href="#">Specialist coinsurance</a>                        | 10%   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 10%   |
| ■ Other ( <a href="#">coinsurance</a> )                         | 10%   |

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

|                                        |                 |
|----------------------------------------|-----------------|
| <b>Total Example Cost</b>              | <b>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| <a href="#">Deductibles</a>            | \$100           |
| <a href="#">Copayments</a>             | \$10            |
| <a href="#">Coinsurance</a>            | \$1,200         |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$60            |
| <b>The total Peg would pay is</b>      | <b>\$1,370</b>  |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$100 |
| ■ <a href="#">Specialist coinsurance</a>                        | 10%   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 10%   |
| ■ Other ( <a href="#">coinsurance</a> )                         | 10%   |

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$5,600</b> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$100          |
| <a href="#">Copayments</a>             | \$200          |
| <a href="#">Coinsurance</a>            | \$100          |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$20           |
| <b>The total Joe would pay is</b>      | <b>\$420</b>   |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$100 |
| ■ <a href="#">Specialist coinsurance</a>                        | 10%   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 10%   |
| ■ Other ( <a href="#">coinsurance</a> )                         | 10%   |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$2,800</b> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$100          |
| <a href="#">Copayments</a>             | \$50           |
| <a href="#">Coinsurance</a>            | \$200          |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$350</b>   |

# Important Information

SummaCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, gender identity or sex.

SummaCare does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, gender identity or sex.

SummaCare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services.

If you believe that SummaCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, religion, gender identity or sex, you can file a grievance through Member Services:

Civil Rights Coordinator  
PO Box 1107  
Akron, OH 44309-1107  
Toll-free: 800.996.8701  
TTY: 800.750.0750  
Fax: 330.996.8545  
Email: [appeals@summacare.com](mailto:appeals@summacare.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Customer Service Representative is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 800.368.1019, 800.537.7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Important Information Language Access Services:

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de SummaCare, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-996-8701.

Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de SummaCare. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-800-996-8701.

如果您，或是您正在協助的對象，有關於 插入 SBM 項目的名稱 SummaCare 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字1-800-996-8701。

本通知有重要的訊息。本通知有關於您透過 插入SBM 項目的名稱 SummaCare 提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 在此插入數字1-800-996-8701。

Falls Sie oder jemand, dem Sie helfen, Fragen zum SummaCare haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-800-996-8701 an.

Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch SummaCare. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-800-996-8701.

صوصخب قئلسأ هدهاست صخش بدل وأ كيدل ناك نإ 1-800-996-8701. ب لصتا SummaCare ، تامولعملاو دعامسلا بلع لوصحلا يف قحلا كيدلف مجرتم عم ثدحتلل .ةفلكت قيا نود نم كتغلب ةيرورضلا

لالخ نم ةيطغتلا بلع لوصحلا كبلط صوصخب ةمهم تامولعم راعشالا اذه يوحى .ةماه تامولعم راعشالا اذه يوحى عفد يف دعامسلل وا ةيحصلا كتيطغت بلع .SummaCare اذه يف ةماهلا خيراوتلا نع ثحبا ظافحل ةنياعم خيراوت يف ءارجا ذااختال جاتحت دق .راعشالا ب لصتا .ةفلكت يا نود نم كتغلب دعامسلاو تامولعملا بلع روصحلا يف قحلا كل .فيلاكتلا 1-800-996-8701

## Important Information

Wann du hoscht en Froog, odder ebber, wu du helpscht, hot en Froog baut SummaCare, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-800-996-8701 uffrufe.

**Die Bekanntmachung gebt wichdichi Auskunft.** Die Bekanntmachung gebt wichdichi Auskunft baut dei Application oder Coverage mit SummaCare. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу SummaCare, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-996-8701.

Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через SummaCare. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 1-800-996-8701.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de SummaCare, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-996-8701.

Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de SummaCare. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez 1-800-996-8701.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về SummaCare, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-800-996-8701.

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình SummaCare. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1-800- Isin yookan namni biraa isin deeggartan SummaCare irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-800-996-8701 tiin bilbilaa.

# Important Information

**Beeksisni kun odeeffannoo barbaachisaa qaba.** Beeksisti kun sagantaa yookan karaa SummaCare tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhuma irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 1-800-996-8701 tii bilbilaa.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 SummaCare 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-800-996-8701로 전화하십시오.

본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 SummaCare를 통한 커버리지 에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 1- 800-996-8701 로 전화하십시오.

Se tu o qualcuno che stai aiutando avete domande su SummaCare, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-800-996-8701.

Questo avviso contiene informazioni importanti sulla tua domanda o copertura attraverso SummaCare. Cerca le date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 1-800-996-8701.

ご本人様、またはお客様の身の回りの方でも、SummaCareについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入力したりすることができます。料金はかかりません。通訳とお話される場合、1-800-996-8701までお電話ください。

この通知には重要な情報が含まれています。この通知には、SummaCareの申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。1-800-996-8701までお電話ください。

## Important Information

Als u, of iemand die u helpt, vragen heeft over SummaCare, heeft u het recht om hulp en informatie te krijgen in uw taal zonder kosten. Om te praten met een tolk, bel 1-800-996-8701.

Deze mededeling heeft belangrijke informatie. Deze mededeling heeft belangrijke informatie over uw aanvraag of dekking via SummaCare. Kijk naar belangrijke datums in deze mededeling. Het kan nodig zijn om actie te ondernemen binnen bepaalde termijnen om uw zorgverzekering te behouden of hulp met kosten te krijgen. U heeft het recht op deze informatie en hulp in uw taal zonder kosten. Bel 1-800-996-8701.

Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про SummaCare, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на 1-800-996-8701.

Це повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про Ваше звернення щодо страхувального покриття через SummaCare. Зверніть увагу на ключові дати, вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 1-800-996-8701.

Dacă dumneavoastră sau persoana pe care o asistați aveți întrebări privind SummaCare, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la 1-800-996-8701.

Prezenta notificare conține informații importante. Această notificare conține informații importante privind cererea sau acoperirea asigurării dumneavoastră de sănătate prin SummaCare. Căutați datele cheie din această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 1-800-996-8701.