SUMMACARE HMO SILVER 830-87
WITH 3 FREE PCP VISITS
SCHEDULE OF BENEFITS

SummaCare℠

Enrollee Services	What the Member Pays (Network Providers only)
Per Member/Per Family Calendar Year Deductible *(Medical and Prescription deductibles are combined and apply where noted.)*	$830/$1,660
Per Member/Per Family Calendar Year Out-of-Pocket Maximum *(Includes deductible, coinsurance and copays. Once an individual family member has met their individual out-of-pocket, claims will be paid at 100% even if the family out-of-pocket has not been met.)*	$3,400/$6,800 (Does not include expenses paid for non-covered services)
Coinsurance *(**What the member pays** after the deductible is met but before the out-of-pocket maximum is reached; after the out-of-pocket maximum is reached services are covered at 100%)*	20%
Annual Dollar Limits on Essential Benefits per Calendar Year	Unlimited
Lifetime Benefit Maximum	Unlimited
OFFICE SERVICES	
Primary Physician Visit *(Applies to office visit fee. First three visits limit is combined for Primary Physician and Mental Health outpatient visits. Other services received during office visit, including diagnostic services, may be subject to deductible and coinsurance. Preventive services not subject to copay, deductible or coinsurance.)*	$0 copay for first three visits; then $10 copay per visit
Preventive Care *(Includes immunizations, well-child care and preventive services as defined by the United States Preventive Services Task Force under grades A and B preventive services. Also includes Women's Health Preventive Services such as mammograms, sterilizations and annual routine gynecological visit.)*	No Cost Share, no copay, coinsurance or deductible for in-network services
Gynecological Visits *(Applies to office visit fee. Preventive services are provided at No Cost Share including annual routine visit; see Preventive Care above.)*	$10 copay per visit
Specialist Visits and Allergist Visits *(Applies to office visit fee. Other services received during office visit, including diagnostic services, may be subject to deductible and coinsurance. Preventive services are provided at No Cost Share. No referral required.)*	20% coinsurance per visit (Subject to deductible) 0% coinsurance injections only
INPATIENT HOSPITAL STAY AND SERVICES (Requires Prior Authorization)	
Inpatient Care *(Includes charges for physician and facility)* Refer to Skilled Nursing benefit for Inpatient Skilled Nursing services and limits.	20% coinsurance (Subject to deductible)
Surgical Services *(Includes Temporomandibular (TMJ) or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder; breast and other reconstruction after surgery, as well as physician, facility and anesthesiologist services)*	20% coinsurance (Subject to deductible)
Rehabilitative Services *(Limited to a combined maximum of 60 days per benefit period for both Inpatient and Outpatient day rehabilitation therapy services.)*	20% coinsurance (Subject to deductible)
MATERNITY SERVICES	
Maternity Office Visits *(Applies to office visit fee. Other services received during office visit, including diagnostic services, may be subject to deductible and coinsurance.)*	$10 copay for initial office visit; then $0 copay
Hospital Services *(48 hours for vaginal delivery; 96 hours for Cesarean delivery; if discharged early, home care is covered for up to 72 hours after discharge)*	20% coinsurance (Subject to deductible)
Postnatal Care	20% coinsurance (Subject to deductible)
Preventive Care Services - Women's Health	No Cost Share
OUTPATIENT SERVICES	
X-ray, Laboratory & Other Diagnostic Services *(May require prior authorization)*	20% coinsurance (Subject to deductible)
Outpatient Facility Fee *(Includes services at a hospital or other alternative care facility or ambulatory surgical care center)*	20% coinsurance (Subject to deductible)
Outpatient Physician & Surgical Services	20% coinsurance (Subject to deductible)
EMERGENCY/URGENT CARE SERVICES	
Emergency Care *(Any hospital emergency room visit inside or outside of the service area)*	20% coinsurance (Subject to deductible)
Urgent Care *(Urgently needed care that is not life- or limb-threatening)*	20% coinsurance (Subject to deductible)

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MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (Biologically and Non-Biologically Based Mental Health and Substance Abuse Disorders)	
Inpatient	20% coinsurance (Subject to deductible)
Outpatient (*First three visits limit is combined for Primary Physician and Mental Health outpatient visits.)*	$0 copay for first three visits; then $10 copay per visit
OTHER SERVICES	
Allergy Tests and Treatment	See Specialist Visits and Allergists Visits above
Clinical Cancer Trials	20% coinsurance (Subject to deductible)
Ambulance Services	20% coinsurance (Subject to deductible)
Chiropractic Services (*Limited to 12 visits per calendar year*)	$10 copay per visit
Dental Services Related to Accidental Injury *(Limited to $3,000 per episode)*	20% coinsurance (Subject to deductible)
Diabetic Eye Exam *(Limited to one visit per calendar year)*	No Cost Share
Diabetic Education and Testing Supplies *(Includes test strips, lancets, control solution)*	Copayment based on setting where education received; testing supplies 20% coinsurance (Subject to deductible)
Dialysis Services	20% coinsurance (Subject to deductible)
Durable Medical Equipment, Supplies, Prosthetic Devices and Foot Orthotics	20% coinsurance (Subject to deductible)
Home Health Care *(Includes infusion therapy; Home health care limited to 100 visits per calendar year; Deductible does not apply to IV Therapy; Limits do not apply to Infusion Therapy and private duty nursing)*	20% coinsurance (Subject to deductible) 20% coinsurance for IV Therapy
Hospice Services	20% coinsurance (Subject to deductible)
Infertility Diagnosis and Treatment	20% coinsurance (Subject to deductible)
Podiatry Services	20% coinsurance (Subject to deductible)
Rehabilitative Services *(Limited to 20 visits Occupational Therapy; 20 visits Physical Therapy; 20 visits Speech Therapy; 36 visits Cardiac Rehabilitation; 20 visits Pulmonary. Visit limits per calendar year when rendered at an outpatient rehab facility.)*	$10 copay per visit for Occupational Therapy and Physical Therapy; 20% coinsurance (Subject to deductible) for all other Rehabilitative Services
Habilitative *(Habilitative services will be determined by SummaCare and are included in the Mental Health and Rehabilitative Service Benefit. Also included are Habilitative Services with a medical diagnosis of Autism Spectrum disorder). Habilitative services include:* *Outpatient Physical Rehab, including Speech and Language Therapy and Occupational Therapy, performed by a licensed therapist, limited to 20 visits per service; Clinical Therapeutic Intervention defined as therapies supported by empirical evidence, which includes but are not limited to, Applied Behavioral Analysis, provided by or under the supervision of a professional who is licensed, certified or registered by an appropriate agency of this state to perform the services in accordance with a treatment plan, 20 hours per week; and Mental/ Behavioral Health Outpatient Services performed by a licensed psychologist, psychiatrist or physician to provide consultation, assessment, development and oversight of treatment plans).*	$10 copay per visit for Occupational Therapy and Physical Therapy 20% coinsurance (Subject to deductible) for all other Rehabilitative Services $10 copay per visit for mental health
Skilled Nursing Facility *(Limited to 90 days per calendar year)*	20% coinsurance (Subject to deductible)
Sterilization Procedures	No cost share for females (see Preventive Care benefit); 20% coinsurance (Subject to deductible)
Teladoc Visits	$10 copay per visit for general medical and behavioral health issues; 20% coinsurance per visit (Subject to deductible) for dermatology issues
Transplant Services *(Unrelated donor search services limited to $30,000 per transplant; approved transportation and lodging covered up to $10,000 per transplant)*	20% coinsurance (Subject to deductible)
Vision Exam *(One routine refraction per year; eye exams for medical conditions of the eye)*	Not Covered
Vision Hardware *($100 allowance for vision hardware every 24 months)*	Not Covered

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PEDIATRIC VISION **For members through the end of the month that the member turns age 19 (Administered through VSP>**	
Pediatric Vision *(Includes Well Vision Exam (with Dilation as Necessary); Vision Acuity Screening; Frames; Standard Prescription Lenses; Contact Lens Fitting, Evaluation and Lenses; Optional Lenses and Treatments; and Low Vision Services.)*	No Cost Share
HEARING AIDS **For members age 21 or younger who are verified as being deaf or hearing impaired (Administered through Amplifon)**	
Hearing Aids *(Coverage includes one hearing aid per hearing-impaired ear up to $2,500 every 48 months and all related services prescribed by an otolaryngologist or recommended by a licensed audiologist and dispensed by a licensed audiologist, a licensed hearing aid dealer or fitter or an otolaryngologist.)*	No Cost Share for up to $2,500 per ear every 48 months
PRESCRIPTION DRUGS	
Prescription Drugs 30-day supply for Retail and Specialty Pharmacy 90-day supply for Mail Order Pharmacy *(Day supply may be less than the amount shown due to prior authorization, quantity limits and utilization guidelines. SummaCare's pharmacy network includes national pharmacy coverage; use contracted national pharmacies whenever possible to save on out-of-pocket costs. Use of specialty pharmacy in-network for up to a 30-day supply.)*	Medical and prescription drug deductibles are combined and apply where noted.
Tier 1: Zero Cost Share Preventive Drugs	No cost share; not subject to deductible
Tier 2: Preferred Generics	$5 copay per prescription for a 30-day supply retail at a participating pharmacy. $15 copay per prescription for a 90-day supply retail at a participating pharmacy. $10 copay per prescription for a 90-day supply through our mail order pharmacy.
Tier 3: Non-Preferred Generics	$15 copay per prescription for a 30-day supply retail at a participating pharmacy. $45 copay per prescription for a 90-day supply retail at a participating pharmacy. $30 copay per prescription for a 90-day supply through our mail order pharmacy.
Tier 4: Preferred Brand	40% coinsurance (Subject to deductible) per prescription for a 30-day or 90-day supply retail at a participating pharmacy or a 90-day supply through our mail order pharmacy.
Tier 5: Non-Preferred Brand	45% coinsurance (Subject to deductible) per prescription for a 30-day or 90-day supply retail at a participating pharmacy or a 90-day supply through our mail order pharmacy.
Tier 6: Specialty Drugs	50% coinsurance (Subject to deductible) per prescription for a 30-day supply at a participating specialty pharmacy. No Mail Order for Specialty Tier 6 Drugs

For benefits or coverage questions call SummaCare Member Services at 330.996.8700 or 800.996.8701 (TTY: 711) or visit www.summacare.com. SummaCare does not discriminate on the basis of race, color, national origin, disability, age, sex, gender, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

Eligible American Indians are exempt from cost-sharing requirements when covered services are rendered by Indian health care providers, which include health programs operated by the Indian Health Service, tribes and tribal organizations and urban Indian organizations, or through referral under contract health services.