SUMMACARE MEWA MPLAN 3A 5000 HSA MOFD
CHAMBER HEALTH BENEFITS PLAN
SCHEDULE OF BENEFITS

Enrollee Services	In-Network (Preferred Provider)	Out-of-Network (Non-Preferred Provider)
Single/Family-Calendar Year Deductible *(In-Network and Out-of-Network Deductibles are separate.) Deductible applies as Noted. If you have other family members in this plan, they have to meet their own deducible limits until the overall family deductible limit has been met.*	$5,000/$10,000	$15,000/$30,000
Single/Family Calendar Year Out Of Pocket Maximum *(Includes Deductible, Coinsurance and Copays. In- and out-of- network out-of-pockets are separate. Each family member enrolled has a self-only out of pocket maximum. Once an individual meets their self-only out of pocket maximum, claims will pay at 100% regardless if the family out of pocket maximum has been met. For a family, once the family out of pocket is met all family members' claims will pay at 100% of the Maximum Allowable Charge)*	$6,650/$13,300	$19,950/$39,900
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% of the Maximum Allowable Charge)*	0%	50% Maximum Allowable Charge
Lifetime Benefit Maximum	Unlimited	
Office Services Copays "What the Member Pays"		Maximum Allowable Charge
Primary Physician Visits *(Preventive Services paid under Preventive Benefit)*	$25 copay per visit (Subject to deductible)	50% (Subject to deductible)
Gynecological Visits (*Preventive Services paid under Preventive Benefit)*	$25 copay per visit (Subject to deductible)	50% (Subject to deductible)
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 listing. Also includes Women's Health Act Preventive Services)*	No Cost Sharing	50% (Subject to deductible)
Specialist Visits *(Preventive Services paid under Preventive Benefit)*	$50 copay per visit (Subject to deductible)	50% (Subject to deductible)
Inpatient Hospital Stay and Services (Requires Prior Authorization)		
Inpatient Care (*Includes charges for physician and facility*) *Refer to Skilled Nursing for Inpatient Skilled Nursing services.*	0% (Subject to deductible)	50% (Subject to deductible)
Inpatient Rehabilitative Services (*Limited to 60 days after first treatment)*	0% (Subject to deductible)	50% (Subject to deductible)
Maternity Services		
Office Visits and Prenatal Care *(Preventive Services paid under Preventive Benefit)*	$25 copay for initial visit (Subject to deductible)	50% (Subject to deductible)
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)*	0% (Subject to deductible)	50% (Subject to deductible)
Postpartum Care	0% (Subject to deductible)	50% (Subject to deductible)

SUMMACARE MEWA MPLAN 3A 5000 HSA MOFD
CHAMBER HEALTH BENEFITS PLAN
SCHEDULE OF BENEFITS

SummaCare℠

Enrollee Services	In-Network (Preferred Provider)	Out-of-Network (Non-Preferred Provider)
Outpatient Services		
X-ray, Laboratory & Other Diagnostic Services (*May require prior authorization*)	0% (Subject to deductible)	50% (Subject to deductible)
Outpatient Surgery and Services (*Includes services at a hospital or other alternative care facility or ambulatory surgical care center*)	0% (Subject to deductible)	50% (Subject to deductible)
Emergency/Urgent Care Services		
Emergency Care (*Any hospital emergency room visit inside or outside of the service area*)	$300 copay (Subject to deductible); Copay waived if admitted	$300 copay (Subject to deductible); Copay waived if admitted. (Subject to Balance Billing)
Urgent Care (*Urgently needed care that is not life- or limb-threatening*)	$60 copay (Subject to deductible)	50% (Subject to deductible)
Mental Health and Substance Abuse Services (Biologically and Non-Biologically Based Mental Health and Substance Abuse Disorders)		
Inpatient	0% (Subject to deductible)	50% (Subject to deductible)
Outpatient	$25 copay per visit (Subject to deductible)	50% (Subject to deductible)
Other Services		
Allergy Tests and Treatment	$50 copay per visit (Subject to deductible) (Injections only-no copay)	50% (Subject to deductible)
Ambulance Services	0% (Subject to deductible)	50% (Subject to deductible)
Chiropractic Services (*Limited to 15 visits per calendar year*)	$50 copay per visit (Subject to deductible)	50% (Subject to deductible)
Durable Medical Equipment	0% (Subject to deductible)	50% (Subject to deductible)
Home Health Care (*Limited to 30 visits per calendar year)*	0% (Subject to deductible)	50% (Subject to deductible)
Hospice Services	0% (Subject to deductible)	50% (Subject to deductible)
Infertility Diagnosis	0% (Subject to deductible)	50% (Subject to deductible)
Rehabilitative Services (*Physical/occupational limited to 30 visits per calendar year combined) (Speech therapy limited to 30 visits per calendar year) (Cardiac/pulmonary limited to 36 visits per calendar year)*	$50 copay per visit (Subject to deductible)	50% (Subject to deductible)
Skilled Nursing Facility	0% (Subject to deductible) (Limited to 100 days per calendar year)	50% (Subject to deductible) (Limited to 30 days per calendar year)
Telemedicine Visits	$25 copay per visit (Subject to deductible)	Not covered
Vision Exam *(one routine exam every 24 months)*	$50 copay per visit (Subject to deductible)	50% (Subject to deductible)

SUMMACARE MEWA MPLAN 3A 5000 HSA MOFD
CHAMBER HEALTH BENEFITS PLAN
SCHEDULE OF BENEFITS

Enrollee Services	In-Network (Preferred Provider)	Out-of-Network (Non-Preferred Provider)
Prescription Drugs		
Prescription Drugs 30-day supply for Specialty Pharmacy 90-day supply for Retail and 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 in- and out-of-network 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.	Medical and prescription drug deductibles are combined and apply where noted.
Tier 1: Preferred Generics	$15 copay per prescription (Subject to deductible) for up to a 30-day supply retail at a participating pharmacy. $45 copay per prescription (Subject to deductible) for up to a 90-day supply retail at a participating pharmacy. $30 copay per prescription (Subject to deductible) for up to a 90-day supply through our mail order pharmacy.	$25 copay per prescription (Subject to deductible) for up to a 30-day supply retail at a participating pharmacy. $75 copay per prescription (Subject to deductible) for up to a 90-day supply retail at a participating pharmacy.
Tier 2: Non-Preferred Generics / Preferred Brand	$35 copay per prescription (Subject to deductible) for up to a 30-day supply retail at a participating pharmacy. $105 copay per prescription (Subject to deductible) for up to a 90-day supply retail at a participating pharmacy. $87.50 copay per prescription (Subject to deductible) for up to a 90-day supply through our mail order pharmacy.	$45 copay per prescription (Subject to deductible) for up to a 30-day supply retail at a participating pharmacy. $135 copay per prescription (Subject to deductible) for up to a 90-day supply retail at a participating pharmacy.
Tier 3: Non-Preferred Brand	$75 copay per prescription (Subject to deductible) for up to a 30-day supply retail at a participating pharmacy. $225 copay per prescription (Subject to deductible) for up to a 90-day supply retail at a participating pharmacy. $187.50 copay per prescription (Subject to deductible) for up to a 90-day supply through our mail order pharmacy.	$95 copay per prescription (Subject to deductible) for up to a 30-day supply retail at a participating pharmacy. $285 copay per prescription (Subject to deductible) for up to a 90-day supply retail at a participating pharmacy.
Tier 4: Specialty Drugs	25% coinsurance per prescription up to $250 (Subject to deductible) for up to a 30-day supply retail at a participating specialty pharmacy. No Mail Order for Specialty Tier 4 Drugs	45% coinsurance per prescription up to $250 (Subject to deductible) for up to a 30-day supply retail at a participating specialty pharmacy.

For benefits or coverage questions call SummaCare Customer Service at 330-252-5925 or 844-751-0437 (TTY 800-750-0750) or visit www.summacare.com.