SUMMACARE MEWA MPLAN 16A 2500 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, the overall family deductible limit must be met.*	$2,500/$5,000	$7,500/$15,000
Single/Family Calendar Year Out Of Pocket Maximum *(Includes Deductible, Coinsurance and Copays. Does not include expenses paid for non-covered services. 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)*	$3,000/$6,000	$9,000/$18,000
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)*	0% (Subject to deductible)	50% (Subject to deductible)
Gynecological Visits (*Preventive Services paid under Preventive Benefit)*	0% (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)*	0% (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)*	0% (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)

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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*)	0% (Subject to deductible)	0% (Subject to deductible)
Urgent Care (*Urgently needed care that is not life- or limb-threatening*)	0% (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	0% (Subject to deductible)	50% (Subject to deductible)
Other Services		
Allergy Tests and Treatment	0% (Subject to deductible)	50% (Subject to deductible)
Ambulance Services	0% (Subject to deductible)	50% (Subject to deductible)
Chiropractic Services (*Limited to 15 visits per calendar year*)	0% (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)*	0% (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	0% (Subject to deductible)	Not covered
Vision Exam *(one routine exam every 24 months)*	0% (Subject to deductible)	50% (Subject to deductible)
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	Not Covered

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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 Member Services at **330.996.8515** or **800.753.8429 (TTY: 711)** or visit **www.summacare.com**.