

SummaCare MEWA M Plan 12 \$500



Chamber Benefit Trust

Schedule of Benefits

Enrollee Services	Enrollee Copayments & Coverage		Enrollee Copayments & Coverage
	Tier I Preferred Provider	Tier II Preferred Provider	Tier III Non Preferred Provider
Calendar Year Deductible:	\$500/\$1,000 (Only applies where noted)	\$1,000/\$2,000 (Only applies where noted) Tier II deductible expenses are applicable to Tier I deductible	\$2,000/\$4,000 (Only applies where noted)
Calendar Year Out of Pocket Maximum: (Includes Deductible)	\$3,500/\$7,000	\$4,500/\$9,000 Tier II OOP expenses count toward Tier I out of pocket maximum	\$7,500/\$15,000
Coinsurance: (what the plan pays)	80%	65%	50% of SummaCare's Maximum Allowable Charge
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Office Services Copays What the Member Pays			Coverage Based on Maximum Allowable Charge
Primary Physician Visits (Preventive Services paid under preventive benefit)	\$20	\$30	50% (Subject to deductible)
Gynecological Visits (Preventive services paid under preventive benefit)	\$20	\$30	50% (Subject to deductible)
Preventive Care (Includes immunizations, well-child care and preventive services as defined by the United States Preventive Care Task Force under grades A and B listing. It also includes Women's Health Act Preventive Services)	No cost sharing	No cost sharing	50% (Subject to deductible)
Specialist Visits	\$40	\$50	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	80% (Subject to deductible)	65% (Subject to deductible)	50% (Subject to deductible)
Inpatient Rehabilitative Services (limited to 60 days after first treatment)	80% (Subject to deductible)	65% (Subject to deductible)	50% (Subject to deductible)
X-ray, Laboratory and other Diagnostic Services	80% (Subject to deductible)	65% (Subject to deductible)	50% (Subject to deductible)

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Maternity Services:			
Office Visits and Prenatal Care	\$20 copay for initial visit	\$30 copay for initial visit	50% (Subject to deductible)
Hospital Services <i>(48 hours for vaginal delivery; 96 hours for Cesarean delivery) (if discharged early, home care is covered for up to 72 hours after discharge) (Requires notification)</i>	80% (Subject to deductible)	65% (Subject to deductible)	50% (Subject to deductible)
Postpartum Care	80% (Subject to deductible)	65% (Subject to deductible)	50% (Subject to deductible)
Outpatient Services:			
X-ray, Laboratory and Other Diagnostic Services <i>(May require Prior Authorizations)</i>	80% (Subject to deductible)	65% (Subject to deductible)	50% (Subject to deductible)
Outpatient Surgery and Services <i>(Includes services at a hospital or alternative care facility or ambulatory surgical care center)</i>	80% (Subject to deductible)	65% (Subject to deductible)	50% (Subject to deductible)
Emergency/Urgent Care Services:			
Emergency Care <i>(any hospital emergency room visit inside or outside the service area)</i>	\$300 copay (Copay waived if admitted)	\$300 copay (Copay waived if admitted)	\$300 copay (Copay waived if admitted) (May be subject to balance billing)
Urgent Care <i>(Urgently needed care that is not life threatening)</i>	\$60 copay	\$60 copay	50% (Subject to deductible)
Mental Health and Substance Abuse Services:			
Inpatient	80% (Subject to deductible)	65% (Subject to deductible)	50% (Subject to deductible)
Outpatient	\$20 copay per visit	\$30 copay per visit	50% (Subject to deductible)
Other Services:			
Allergy Tests and Treatment	\$40 copay per visit (Injections only- no copay)	\$50 copay per visit (Injections only- no copay)	50% (Subject to deductible)
Ambulance Services	80% (Subject to deductible)	80% (Subject to deductible)	50% (Subject to deductible)
Chiropractic Services <i>(Limited to 15 visits per calendar year)</i>	\$50 copay per visit	\$60 copay per visit	50% (Subject to deductible)
Durable Medical Equipment	80% (Subject to deductible) Available through Homelink	80% (Subject to deductible) Available through Homelink	50% (Subject to deductible)
Home Health Care <i>(Limited to 30 visits per calendar year)</i>	80% (Subject to deductible)	65% (Subject to deductible)	50% (Subject to deductible)
Hospice Services	80% (Subject to deductible)	65% (Subject to deductible)	50% (Subject to deductible)
Infertility Diagnosis	80% (Subject to deductible)	65% (Subject to deductible)	50% (Subject to deductible)

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Rehabilitative Services <i>(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)</i>	\$40 copay per visit	\$50 copay per visit	50% (Subject to deductible)
Skilled Nursing Facility	80% (Subject to deductible)	65% (Subject to deductible)	50% (Subject to deductible)
Telemedicine Visits	\$20 copay per visit	Not applicable	No coverage
Vision Exam <i>(one routine exam per 24 months)</i>	\$50 copay per visit	\$50 copay per visit	50% (Subject to deductible)
Prescription Drugs	MOF RX Rider \$15/\$35/\$75/\$25% to maximum of \$250		Not covered

TIER I Providers

SC Connect

TIER II Providers

SC Premier (minus providers participating in SC Connect)