**SUMMACARE PPO MPLAN 2 6000 MOF**
**CHAMBER BENEFIT TRUST**
**SCHEDULE OF BENEFITS**

| Enrollee Services | In-Network (Preferred Provider) | Out-of-Network (Non-Preferred Provider) |
|---|---|---|
| Single/Family-Calendar Year Deductible<br>*(In-Network and Out-of-Network Deductibles are separate.) Deductible applies as Noted.* | $6,000/$12,000 | $12,000/$24,000 |
| Single/Family Calendar Year Out Of Pocket Maximum<br>*(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)* | $7,350/$14,700 | $20,000/$40,000 |
| Coinsurance<br>*(What the plan 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)* | 100% | 60% Maximum Allowable Charge |
| Lifetime Benefit Maximum | Unlimited | |
| Office Services Copays "What the Member Pays" | | Maximum Allowable Charge |
| Primary Physician Visits<br>*(Preventive Services paid under Preventive Benefit)* | $25 copay per visit | 60% (Subject to deductible) |
| Gynecological Visits<br>(*Preventive Services paid under Preventive Benefit)* | $25 copay per visit | 60% (Subject to deductible) |
| Preventive Care<br>*(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 | 60% (Subject to deductible) |
| Specialist Visits<br>*(Preventive Services paid under Preventive Benefit)* | $60 copay per visit | 60% (Subject to deductible) |
| Inpatient Hospital Stay and Services<br>(Requires Prior Authorization) | | |
| Inpatient Care<br>(*Includes charges for physician and facility*)<br>*Refer to Skilled Nursing for Inpatient Skilled Nursing services.* | 100% (Subject to deductible) | 60% (Subject to deductible) |
| Inpatient Rehabilitative Services<br>(*Limited to 60 days after first treatment)* | 100% (Subject to deductible) | 60% (Subject to deductible) |
| Maternity Services | | |
| Office Visits and Prenatal Care<br>*(Preventive Services paid under Preventive Benefit)* | $25 copay for initial visit | 60% (Subject to deductible) |
| Hospital Services<br>*(48 hours for vaginal delivery; 96 hours for Cesarean delivery; if discharged early, home care is covered for up to 72 hours after discharge)* | 100% (Subject to deductible) | 60% (Subject to deductible) |
| Postpartum Care | 100% (Subject to deductible) | 60% (Subject to deductible) |

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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*) | 100% (Subject to deductible) | 60% (Subject to deductible) |
| Outpatient Surgery and Services (*Includes services at a hospital or other alternative care facility or ambulatory surgical care center*) | 100% (Subject to deductible) | 60% (Subject to deductible) |
| **Emergency/Urgent Care Services** | | |
| Emergency Care (*Any hospital emergency room visit inside or outside of the service area*) | $300 copay; Copay waived if admitted | $300 copay; Copay waived if admitted. (Subject to Balance Billing) |
| Urgent Care (*Urgently needed care that is not life- or limb-threatening*) | $60 copay | 60% (Subject to deductible) |
| **Mental Health and Substance Abuse Services** (Biologically and Non-Biologically Based Mental Health and Substance Abuse Disorders) | | |
| Inpatient | 100% (Subject to deductible) | 60% (Subject to deductible) |
| Outpatient | $25 copay per visit | 60% (Subject to deductible) |
| **Other Services** | | |
| Allergy Tests and Treatment | $60 copay per visit (Injections only-no copay) | 60% (Subject to deductible) |
| Ambulance Services | 100% (Subject to deductible) | 60% (Subject to deductible) |
| Chiropractic Services (*Limited to 15 visits per calendar year*) | $60 copay per visit | 60% (Subject to deductible) |
| Durable Medical Equipment | 100% (Subject to deductible) | 60% (Subject to deductible) |
| Home Health Care (*Limited to 30 visits per calendar year)* | 100% (Subject to deductible) | 60% (Subject to deductible) |
| Hospice Services | 100% (Subject to deductible) | 60% (Subject to deductible) |
| Infertility Diagnosis | 100% (Subject to deductible) | 60% (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)* | $60 copay per visit | 60% (Subject to deductible) |
| Skilled Nursing Facility | 100% (Subject to deductible) (Limited to 100 days per calendar year) | 60% (Subject to deductible) (Limited to 30 days per calendar year) |
| Telemedicine Visits | $25 copay per visit | 60% (Subject to deductible) |
| Vision Exam *(one routine exam every 24 months)* | $60 copay per visit | 60% (Subject to deductible) |

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| Enrollee Services | In-Network (Preferred Provider) | Out-of-Network (Non-Preferred Provider) |
|---|---|---|
| Prescription Drugs | | |
| Prescription Drugs<br>30-day supply for Specialty Pharmacy<br>90-day supply for Retail and Mail Order Pharmacy<br>(*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.*) | $0 per person prescription drug deductible | $0 per person prescription drug deductible |
| Tier 1: Preferred Generics | $15 copay per prescription for up to a 30-day supply retail at a participating pharmacy.<br>$45 copay per prescription for up to a 90-day supply retail at a participating pharmacy.<br>$30 copay per prescription for up to a 90-day supply through our mail order pharmacy. | $25 copay per prescription for up to a 30-day supply retail at a participating pharmacy.<br>$75 copay per prescription for up to a 90-day supply retail at a participating pharmacy. |
| Tier 2: Non-Preferred Generics / Preferred Brand | $35 copay per prescription for up to a 30-day supply retail at a participating pharmacy.<br>$105 copay per prescription for up to a 90-day supply retail at a participating pharmacy.<br>$87.50 copay per prescription for up to a 90-day supply through our mail order pharmacy. | $45 copay per prescription for up to a 30-day supply retail at a participating pharmacy.<br>$135 copay per prescription for up to a 90-day supply retail at a participating pharmacy. |
| Tier 3: Non-Preferred Brand | $75 copay per prescription for up to a 30-day supply retail at a participating pharmacy.<br>$225 copay per prescription for up to a 90-day supply retail at a participating pharmacy.<br>$187.50 copay per prescription for up to a 90-day supply through our mail order pharmacy. | $95 copay per prescription for up to a 30-day supply retail at a participating pharmacy.<br>$285 copay per prescription 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.<br>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 330-996-8700 or 800-996-8701 (TTY 800-750-0750) or visit www.summacare.com.