

Enrollee Services	In-Network (Preferred Provider)	Out-of-Network (Non-Preferred Provider)
Single/Family-Calendar Year Deductible <i>(In-Network and Out-of-Network Deductibles are separate.) Deductible applies as Noted.</i>	\$5,000/\$10,000	\$10,000/\$20,000
Single/Family Calendar Year Out Of Pocket Maximum <i>(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)</i>	\$7,000/\$14,000	\$20,000/\$40,000
Coinsurance <i>(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)</i>	100%	60% Maximum Allowable Charge
Lifetime Benefit Maximum	Unlimited	
Office Services Copays "What the Member Pays"		Maximum Allowable Charge
Primary Physician Visits <i>(Preventive Services paid under Preventive Benefit)</i>	\$25 copay per visit	60% (Subject to deductible)
Gynecological Visits <i>(Preventive Services paid under Preventive Benefit)</i>	\$25 copay per visit	60% (Subject to deductible)
Preventive Care <i>(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)</i>	No Cost Sharing	60% (Subject to deductible)
Specialist Visits <i>(Preventive Services paid under Preventive Benefit)</i>	\$50 copay per visit	60% (Subject to deductible)
Inpatient Hospital Stay and Services (Requires Prior Authorization)		
Inpatient Care <i>(Includes charges for physician and facility) Refer to Skilled Nursing for Inpatient Skilled Nursing services.</i>	100% (Subject to deductible)	60% (Subject to deductible)
Inpatient Rehabilitative Services <i>(Limited to 60 days after first treatment)</i>	100% (Subject to deductible)	60% (Subject to deductible)
Maternity Services		
Office Visits and Prenatal Care <i>(Preventive Services paid under Preventive Benefit)</i>	\$25 copay for initial visit	60% (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)</i>	100% (Subject to deductible)	60% (Subject to deductible)
Postpartum Care	100% (Subject to deductible)	60% (Subject to deductible)

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Outpatient Services		
X-ray, Laboratory & Other Diagnostic Services <i>(May require prior authorization)</i>	100% (Subject to deductible)	60% (Subject to deductible)
Outpatient Surgery and Services <i>(Includes services at a hospital or other alternative care facility or ambulatory surgical care center)</i>	100% (Subject to deductible)	60% (Subject to deductible)
Emergency/Urgent Care Services		
Emergency Care <i>(Any hospital emergency room visit inside or outside of the service area)</i>	\$300 copay; Copay waived if admitted	\$300 copay; Copay waived if admitted. (Subject to Balance Billing)
Urgent Care <i>(Urgently needed care that is not life- or limb-threatening)</i>	\$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	\$50 copay per visit (Injections only-no copay)	60% (Subject to deductible)
Ambulance Services	100% (Subject to deductible)	60% (Subject to deductible)
Chiropractic Services <i>(Limited to 15 visits per calendar year)</i>	\$50 copay per visit	60% (Subject to deductible)
Durable Medical Equipment	100% (Subject to deductible)	60% (Subject to deductible)
Home Health Care <i>(Limited to 30 visits per calendar year)</i>	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 <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>	\$50 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 <i>(one routine exam every 24 months)</i>	\$50 copay per visit	60% (Subject to deductible)

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Prescription Drugs		
Prescription Drugs 30-day supply for Specialty Pharmacy 90-day supply for Retail and Mail Order Pharmacy <i>(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.)</i>	\$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. \$45 copay per prescription for up to a 90-day supply retail at a participating pharmacy. \$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. \$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. \$105 copay per prescription for up to a 90-day supply retail at a participating pharmacy. \$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. \$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. \$225 copay per prescription for up to a 90-day supply retail at a participating pharmacy. \$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. \$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. 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.