SummaCare MEWA M Plan 13 $1,500

Chamber Benefit Trust

Schedule of Benefits

Enrollee Services	Enrollee Copayments & Coverage *Tier I* *Preferred Provider*	Enrollee Copayments & Coverage *Tier II* *Preferred Provider*	Enrollee Copayments & Coverage *Tier III* *Non Preferred Provider*
Calendar Year Deductible:	$1,500/$3,000 (only applies where noted)	$2,000/$4,000 (only applies where noted) **Tier II deductible expenses are applicable to Tier I deductible**	$4,000/$8,000 (Only applies where noted)
Calendar Year Out of Pocket Maximum: *(Includes Deductible)*	$3,750/$7,500	$5,000/$10,000 **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)

Enrollee Services	Enrollee Copayments & Coverage *Tier I* *Preferred Provider*	Enrollee Copayments & Coverage *Tier II* *Preferred Provider*	Enrollee Copayments & Coverage *Tier III* *Non Preferred Provider*
Maternity Services:			
Office Visits and Prenatal Care	$20 copay for initial visit	$30 copay for initial visit	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)* *(Requires notification)*	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 *(May require Prior Authorizations)*	80% (Subject to deductible)	65% (Subject to deductible)	50% (Subject to deductible)
Outpatient Surgery and Services *(Includes services at a hospital or alternative care facility or ambulatory surgical care center)*	80% (Subject to deductible)	65% (Subject to deductible)	50% (Subject to deductible)
Emergency/Urgent Care Services:			
Emergency Care *(any hospital emergency room visit inside or outside the service area)*	$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 *(Urgently needed care that is not life threatening)*	$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 *(Limited to 15 visits per calendar year)*	$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 *(Limited to 30 visits per calendar year)*	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)

Enrollee Services	Enrollee Copayments & Coverage ***Tier I Preferred Provider***	Enrollee Copayments & Coverage ***Tier II Preferred Provider***	Enrollee Copayments & Coverage ***Tier III Non Preferred Provider***
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)*	$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 *(one routine exam per 24 months)*	$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

<u>TIER I Providers</u>

SC Connect

<u>TIER II Providers</u>

SC Premier (minus providers participating in SC Connect)