

Individual PPO Plan 300

The following is a Schedule of Benefits for the Summa Insurance Company Major Medical Preferred Provider Plan 300. Always refer to your Summa Individual Solutions Policy as well as this Schedule when you have a question about your benefits. For further clarification of specific Summa benefits and coverage and for information about how your policy works, call SummaCare Individual Solutions at (888) 996-8675.

Enrollee Services	Enrollee Copayments & Coverage Preferred Provider	Enrollee Copayments & Coverage Non-Preferred Provider
Calendar Year Deductible	\$300/\$600	\$600/\$1200
Calendar Year Out of Pocket Maximum <small>(includes deductible)</small>	\$2500*/\$5000*	\$5000*/\$10,000*
Coinsurance: <small>(what the plan pays)</small>	80%	60% of Summa's Maximum Allowable Charge
Lifetime Benefit Maximum	\$2,500,000 (allowable charges only) for all Services	\$1,000,000 (allowable charges only) for all Services
Inpatient Hospital Services: (required preauthorization)		Coverage Based Upon Maximum Allowable Charge
Inpatient Care (room and board)	80% (subject to deductible)	60% (subject to deductible)
Surgery & Anesthesia	80% (subject to deductible)	60% (subject to deductible)
Physician Services	80% (subject to deductible)	60% (subject to deductible)
Medically Necessary Supplies & Services <small>(e.g., oxygen, blood, crutches, etc.)</small>	80% (subject to deductible)	60% (subject to deductible)
Rehabilitative Services <small>(limited to 60 days after first treatment)</small>	80% (subject to deductible)	60% (subject to deductible)
X-ray, Laboratory & other Diagnostic Services	80% (subject to deductible)	60% (subject to deductible)
Outpatient Services:		
Outpatient Surgery	80% (subject to deductible)	60% (subject to deductible)
Maternity Services: Not Covered under this plan		
Mental Health and Substance Abuse:		
Inpatient (21 days per calendar year)	80% (subject to deductible)	60% (subject to deductible)
Outpatient-postpartum Care (20 visits per calendar year)	50% (subject to deductible)	50% (subject to deductible)
Emergency Room**/Urgent Care Services:		
Any hospital emergency room visit inside or outside of the service area <small>(life or limb threatening)</small>	80% after \$100 copay; copay waived if admitted	80% after \$100 copay; copay waived if admitted
Urgent Care <small>(urgently needed care that is not life or limb threatening)</small>	100% after \$35 copay at an approved network urgent care center	60% after a \$35 copay at a non-network urgent care facility
Medical Services:		
Primary Care Office Visits	\$15 copay per visit	60% (subject to deductible)
Gynecological Visits	\$15 copay per visit	60% (subject to deductible)
Specialist Office Visits	\$20 copay per visit	60% (subject to deductible)
Annual Physical Exam	\$15 copay per visit	60% (subject to deductible)
Preventive Care <small>(includes immunizations, well child care)</small>	\$15 copay per visit	60% (subject to deductible)
X-ray, Laboratory & other Diagnostic Services	80% (subject to deductible)	60% (subject to deductible)
Mammograms <small>(maximum charge of 130% of Medicare Rates per mammogram)</small>	80% (not subject to deductible)	60% (subject to deductible)
Infertility Diagnosis	50% (subject to deductible)	50% (subject to deductible)
Allergy Tests & Treatment	\$20 copay per visit (injections only - no copay)	60% (subject to deductible)
Other Services:		
Vision Exam <small>(one routine exam every 24 months)</small>	\$20 copay per 24 month visit	60% (subject to deductible)
Skilled Nursing Facility	80% (limited to 100 days per calendar year) (subject to deductible)	60% (limited to 30 days per calendar year) (subject to deductible)
Home Health Care <small>(limited to 30 visits per calendar year)</small>	80% (subject to deductible)	60% (subject to deductible)
Ambulance Services	\$75 copay (waived if admitted)	\$75 copay (waived if admitted)
Hospice Services	80% (subject to deductible)	60% (subject to deductible)
Durable Medical Equipment	80% (subject to deductible)	60% (subject to deductible)
Rehabilitative Services <small>(physical and occupational therapies limited to 30 visits per calendar year combined) (speech therapy limited to 30 visits per year) (cardio pulmonary limited to 36 visits per calendar year)</small>	80% (subject to deductible)	60% (subject to deductible)
Chiropractic Services <small>(limited to 10 visits per calendar year)</small>	70% (subject to deductible)	50% (subject to deductible)
Prescription Drugs Included: copays	\$15/\$30/\$60 or 50% up to a max of \$200, whichever is greater	

Note: Some services require preauthorization for coverage to apply. Verify Preauthorization list in your Policy. All services are subject to medical necessity.

manifests itself by such acute symptoms of severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
- b. Serious impairments to bodily functions.
- c. Serious dysfunctions of any bodily organ or part.

* Copayments DO NOT apply to out of pocket maximum.

** An emergency condition is considered an emergency if it is a condition that