ILENE SHAPIRO
COUNTY EXECUTIVE

County of Summit
Summa

Summa Network

Benefit	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age	Age 26 - Removal upon end of month of 26th birthday	
Benefit Period Deductible – Single/Family	$500/$1,000	$6,400/12,800
Coinsurance	Plan pays 90%; Member pays 10% up to $1,500/$3,000	Plan pays 60%; Member pays 40% up to $17,400/$34,800
Maximum Out-of-Pocket (incudes Deductible, Coinsurance and all Medical and Drug Copays) Single/Family	$7,350 / $14,700	$23,800/$47,600
Physician/Office Services		
Office Visit (Illness/Injury)	$10 PCP/$20 Specialist copay	Plan pays 60% after deductible
Urgent Care Office Visit	$30 copay	Plan pays 60% after deductible
All Immunizations	Plan pays 100%	Plan pays 60% after deductible
Preventive Services		
Preventive Services, in accordance with state and federal law	Plan pays 100%	Plan pays 60% after deductible
Preventive Physical Exam (Ages 21 and over)	Plan pays 100%	Plan pays 60% after deductible
Well Child Care Services including Exam, Routine Vision, Routine Hearing Exams, Well Child Care Immunizations (To age 21)	Plan pays 100%	Plan pays 60% after deductible
Preventive Mammogram (One per benefit period)	Plan pays 100%	Plan pays 60% after deductible
Preventive Pap Test (One per benefit period)	Plan pays 100%	Plan pays 60% after deductible
Preventive PSA (Prostate Specific Antigen)	Plan pays 100%	Plan pays 60% after deductible
Preventive Lab, X-Ray and Medical Tests	Plan pays 100%	Plan pays 60% after deductible
Preventive Endoscopic Services	Plan pays 100%	Plan pays 60% after deductible
Preventive Eye Exam (one per benefit period)	$20 copay then Plan pays 100%	Plan pays 60% after deductible
Preventive Eye Refraction (one per 24 months)	Plan pays 100%	Plan pays 60% after deductible
Outpatient Services		
Surgical Services	Plan pays 90% after deductible	Plan pays 60% after deductible
Diagnostic Services - X-Ray, Medical Tests	Plan pays 90% after deductible	Plan pays 60% after deductible
Diagnostic Lab	Free Standing Facility - $10 Copay; Institutional - Plan pays 90% after Deductible	Plan pays 60% after deductible
Diagnostic and Routine Prostate Specific Antigen (PSA)	Plan pays 100%	Plan pays 60% after deductible
Occupational Therapy (25 visits combined with Physical Therapy then subject to Med Review)	$10 PCP/$20 Specialist	Plan pays 60% after deductible
Physical Therapy (25 visits combined with Occupational Therapy then subject to Med Review)	$10 PCP/$20 Specialist	Plan pays 60% after deductible
Chiropractic Therapy (25 visits then subject to Med Review)	$10 PCP/$20 Specialist	Plan pays 60% after deductible
Speech Therapy (10 visits then subject to Med Review)	$10 PCP/$20 Specialist	Plan pays 60% after deductible
Cardiac Rehabilitation	$10 PCP/$20 Specialist	Plan pays 60% after deductible
Emergency use of an Emergency Room	$150 copay, then 100% - copay waived if admitted	
Non-Emergency use of an Emergency Room	Plan pays 90% after deductible	Plan pays 60% after deductible

Benefit	Network	Non-Network
Inpatient Facility		
Semi-Private Room and Board	Plan pays 90% after deductible	Plan pays 60% after deductible
Maternity	Plan pays 90% after deductible	Plan pays 60% after deductible
Skilled Nursing Facility	Plan pays 90% after deductible	Plan pays 60% after deductible
Additional Services		
Allergy Testing and Treatments	Plan pays 90% after deductible	Plan pays 60% after deductible
Ambulance	Plan pays 90% after deductible	Plan pays 60% after deductible
Durable Medical Equipment	Plan pays 90% after deductible	Plan pays 60% after deductible
Home Healthcare (40 visits per benefit period)	Plan pays 90% after deductible	Plan pays 60% after deductible
Hospice	Plan pays 90% after deductible	Plan pays 60% after deductible
Organ Transplants ($10,000 maximum for patient transportation)	Plan pays 90% after deductible	Plan pays 60% after deductible
Private Duty Nursing	Plan pays 90% after deductible	Plan pays 60% after deductible
Mental Health and Substance Abuse - Federal Mental Health Parity		
Inpatient Mental Health and Substance Abuse Services	**Benefits paid based on corresponding medical benefits**	
Outpatient Mental Health and Substance Abuse		

Note: Services requiring a copayment are not subject to the single/family deductible or coinsurance.

Deductible and coinsurance expenses incurred for services by a non-network provider will also apply to the network deductible and coinsurance out-of-pocket limits. Deductible and coinsurance expenses incurred for services by a network provider will also apply to the non-network deductible and coinsurance out-of pocket limits.

Non-Contracting and Facility Other Providers will pay the same as Non-Network.

Benefits will be determined based on Summa's medical and administrative policies and procedures.

This document is only a partial listing of benefits. This is not a contract of insurance. The contract or benefit booklet will contain the complete listing of covered services. The covered person's coinsurance will always be based on the lesser of the provider's billed charges or Summa's negotiated rate with the provider.