

## Silver Plan Schedule of Benefits

|                                                    | Network: NewHealthConnect Summa Health                                                                                                                                                                                                                      |                                                                                                                           |                                                                                                                           |
|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| Feature/Service                                    | Summa+                                                                                                                                                                                                                                                      | Tier 1                                                                                                                    | Tier 2                                                                                                                    |
| <b>Annual Deductible</b>                           | <ul style="list-style-type: none"> <li>Individual \$1,000</li> <li>Family \$2,000</li> </ul>                                                                                                                                                                | <ul style="list-style-type: none"> <li>Individual \$1,500</li> <li>Family \$3,000</li> </ul>                              | <ul style="list-style-type: none"> <li>Individual \$2,000</li> <li>Family \$4,000</li> </ul>                              |
|                                                    | <b>Note:</b> Tier 2 deductible expenses are applicable toward Summa+ and Tier 1 deductible. Tier 1 deductible expenses are applicable toward Summa+ deductible.                                                                                             |                                                                                                                           |                                                                                                                           |
| <b>Out-of-Pocket Maximum for the Calendar Year</b> | Medical & Pharmacy combined <ul style="list-style-type: none"> <li>Individual \$4,000</li> <li>Family \$8,000</li> </ul>                                                                                                                                    | Medical & Pharmacy combined <ul style="list-style-type: none"> <li>Individual \$6,000</li> <li>Family \$12,000</li> </ul> | Medical & Pharmacy combined <ul style="list-style-type: none"> <li>Individual \$6,850</li> <li>Family \$13,700</li> </ul> |
|                                                    | <b>Note:</b> Tier 2 out-of-pocket expenses are applicable toward Summa+ and Tier 1 out-of-pocket maximum. Tier 1 out-of-pocket expenses are applicable toward Summa+ out-of-pocket maximum.<br>In-Vitro Fertilization and Weight Loss Surgery are excluded. |                                                                                                                           |                                                                                                                           |

|                                          | Network: NewHealthConnect Summa Health                                                                                                                                                                                                                                                                                                                                                                                            |                       |                       |
|------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|
| Covered Services                         | Summa+                                                                                                                                                                                                                                                                                                                                                                                                                            | Tier 1                | Tier 2                |
| <b>Allergy Tests</b>                     | 15% after deductible                                                                                                                                                                                                                                                                                                                                                                                                              | 20% after deductible  | 25% after deductible  |
| <b>Allergy Desensitization Treatment</b> | 15% after deductible                                                                                                                                                                                                                                                                                                                                                                                                              | 20% after deductible  | 25% after deductible  |
| <b>Ambulance</b>                         | \$0 Co-pay                                                                                                                                                                                                                                                                                                                                                                                                                        | \$0 Co-pay            | \$0 Co-pay            |
| <b>Autism</b>                            | \$15 Co-pay per visit                                                                                                                                                                                                                                                                                                                                                                                                             | \$25 Co-pay per visit | \$40 Co-pay per visit |
|                                          | Coverage for ages 0-21 includes: <ul style="list-style-type: none"> <li>Speech and Language Therapy – limited to 20 visits per calendar year</li> <li>Occupational Therapy – limited to 20 visits per calendar year</li> <li>Clinical Therapeutic Intervention, including Applied Behavioral Analysis (ABA) – limited to 20 hours per week</li> <li>Mental/Behavioral Health Outpatient Services (follows MH benefits)</li> </ul> |                       |                       |
| <b>Cardiac Rehab Therapy</b>             | 15% after deductible                                                                                                                                                                                                                                                                                                                                                                                                              | 20% after deductible  | 25% after deductible  |
| <b>Chiropractic Services</b>             | N/A                                                                                                                                                                                                                                                                                                                                                                                                                               | 20% after deductible  | 25% after deductible  |
|                                          | 20 visits per calendar year                                                                                                                                                                                                                                                                                                                                                                                                       |                       |                       |
| <b>Dialysis</b>                          | N/A                                                                                                                                                                                                                                                                                                                                                                                                                               | 20% after deductible  | 25% after deductible  |
| <b>Durable Medical Equipment</b>         | 15% after deductible through HomeLink                                                                                                                                                                                                                                                                                                                                                                                             |                       | No coverage           |

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|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------------|
| <b>Covered Services</b>                                                                                                 | <b>Summa+</b>                                                                                                  | <b>Tier 1</b>                                  | <b>Tier 2</b>                                            |
| <b>Emergency Services</b>                                                                                               | \$250 Co-pay per visit for all emergency service providers; Co-pay waived if admitted to the hospital.         |                                                |                                                          |
| <b>Home Health Care</b>                                                                                                 | 15% after deductible                                                                                           | 20% after deductible                           | 25% after deductible                                     |
| <b>Inpatient Hospital &amp; Facility Services (including Maternity stays – deductible applies to both mom and baby)</b> | 15% after deductible                                                                                           | 20% after deductible                           | 25% after deductible                                     |
|                                                                                                                         | Out-of-network coverage for emergency admissions only. Admissions will be covered at the Tier 2 benefit level. |                                                |                                                          |
| <b>Inpatient Physician Services</b>                                                                                     | 15% after deductible                                                                                           | 20% after deductible                           | 25% after deductible                                     |
| <b>Lab/X-Ray &amp; Other Diagnostic</b>                                                                                 | Lab<br>\$15 Co-pay per visit.                                                                                  | Lab<br>\$30 Co-pay per visit.                  | Lab<br>\$50 Co-pay per visit.                            |
|                                                                                                                         | X-Ray & Other Diagnostic 15% after deductible.                                                                 | X-Ray & Other Diagnostic 20% after deductible. | X-Ray & Other Diagnostic 25% after deductible.           |
|                                                                                                                         | High Tech Imaging 15% after deductible                                                                         | High Tech Imaging 20% after deductible         | High Tech Imaging 25% after deductible                   |
|                                                                                                                         | Summa + Labs:<br>Summa Facility Labs<br>Quest Diagnostics                                                      | Tier 1 Labs:<br>Akron Children's Hospital      | Tier 2 Labs:<br>Aultman Hospital<br>University Hospitals |
| <b>Observation Stay</b>                                                                                                 | 100% after Emergency Room Co-pay                                                                               |                                                |                                                          |
| <b>Outpatient Surgery</b>                                                                                               | 15% after deductible                                                                                           | 20% after deductible                           | 25% after deductible                                     |
|                                                                                                                         | Includes Ambulatory Surgery Center and Outpatient Hospital                                                     |                                                |                                                          |
| <b>Physical/ Occupational Therapy</b>                                                                                   | 15% after deductible                                                                                           | 20% after deductible                           | 25% after deductible                                     |
|                                                                                                                         | 60 visits per calendar year (physical and occupational therapy combined)                                       |                                                |                                                          |
| <b>Physician (PCP) Office Visits (Diagnostic)</b>                                                                       | \$15 Co-pay per visit                                                                                          | \$25 Co-pay per visit                          | \$40 Co-pay per visit                                    |
|                                                                                                                         |                                                                                                                |                                                |                                                          |
|                                                                                                                         | Includes Mental Health and Substance Abuse Office Visits.                                                      |                                                |                                                          |

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| Covered Services                           | Network: NewHealthConnect Summa Health                                                                                                                                                                                                                                                                                                                            |                                                 |                       |
|--------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-----------------------|
|                                            | Summa+                                                                                                                                                                                                                                                                                                                                                            | Tier 1                                          | Tier 2                |
| <b>Preventive Services</b>                 | \$0 Co-pay<br>Preventive Services include: <ul style="list-style-type: none"> <li>• Well childcare visits</li> <li>• Specific women's preventive services</li> <li>• Counseling to prevent illness, disease, or other health problems</li> <li>• Immunizations</li> <li>• Adult preventive visits</li> <li>• Preventive lab work, tests and screenings</li> </ul> |                                                 |                       |
| <b>Radiation Therapy</b>                   | 15% after deductible                                                                                                                                                                                                                                                                                                                                              | 20% after deductible                            | 25% after deductible  |
| <b>Skilled Nursing Facility</b>            | N/A                                                                                                                                                                                                                                                                                                                                                               | 20% after deductible                            | 25% after deductible  |
|                                            | 100 days per calendar year                                                                                                                                                                                                                                                                                                                                        |                                                 |                       |
| <b>Specialist Office Visit</b>             | \$30 Co-pay per visit                                                                                                                                                                                                                                                                                                                                             | \$40 Co-pay per visit                           | \$70 Co-pay per visit |
| <b>Speech Therapy</b>                      | 15% after deductible                                                                                                                                                                                                                                                                                                                                              | 20% after deductible                            | 25% after deductible  |
|                                            | 30 visits per calendar year                                                                                                                                                                                                                                                                                                                                       |                                                 |                       |
| <b>Transplants</b>                         | N/A                                                                                                                                                                                                                                                                                                                                                               |                                                 | 25% after deductible  |
| <b>Urgent Care</b>                         | \$40 Co-pay per visit at any Summa urgent care center                                                                                                                                                                                                                                                                                                             | \$60 Co-pay per visit to any urgent care center |                       |
| <b>Vision Care (Medical)</b>               | \$30 Co-pay per visit                                                                                                                                                                                                                                                                                                                                             | \$40 Co-pay per visit                           | \$70 Co-pay per visit |
| <b>Weight Loss Surgery &amp; Treatment</b> | Surgery = \$1,900 Co-pay after deductible<br>Non-surgical services = covered at the applicable benefit based on services provided.<br>Services are ONLY covered at the Summa Bariatric Center. Contact the Bariatric Center about covered procedures and services at 330-375-6554.                                                                                |                                                 |                       |
| <b>Women's Health</b>                      | \$0 Co-pay<br>Services include: <ul style="list-style-type: none"> <li>• Well-women's visits</li> <li>• Contraceptive methods/devices and sterilization</li> <li>• Breastfeeding counseling, support and pump</li> <li>• Preventive tests and screenings</li> <li>• Counseling to prevent illness, disease, or other health problems</li> </ul>                   |                                                 |                       |

| Medical Drug Benefit (includes chemotherapy, infusions and injections) |                                        |                      |                      |
|------------------------------------------------------------------------|----------------------------------------|----------------------|----------------------|
| Covered Services                                                       | Network: NewHealthConnect Summa Health |                      |                      |
|                                                                        | Summa+                                 | Tier 1               | Tier 2               |
| <b>Office</b>                                                          | 15% after deductible                   | 20% after deductible | 25% after deductible |
| <b>Home</b>                                                            | 15% after                              | 20% after deductible | 25% after deductible |

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|                                                                               |                      |                      |                      |
|-------------------------------------------------------------------------------|----------------------|----------------------|----------------------|
|                                                                               | deductible           |                      |                      |
| <b>Center/Hospital<br/>(if drug is on the<br/>home infusion list)</b>         | 15% after deductible | 20% after deductible | 25% after deductible |
| <b>Center/Hospital<br/>(if drug is NOT on<br/>the home infusion<br/>list)</b> | 15% after deductible | 20% after deductible | 25% after deductible |

| Prescription Drug Benefit |                                                                                  |                                                   |                                                                       |                             |                      |
|---------------------------|----------------------------------------------------------------------------------|---------------------------------------------------|-----------------------------------------------------------------------|-----------------------------|----------------------|
|                           | <b>Summa+<br/>Summa<br/>Health<br/>pharmacies,<br/>Acme, and<br/>Giant Eagle</b> | <b>Summa+<br/>Summa<br/>Health<br/>pharmacies</b> | <b>Retail Pharmacy<br/>All other SummaCare<br/>network pharmacies</b> | <b>Mail Order<br/>Birdi</b> |                      |
|                           | <b>30-day<br/>supply</b>                                                         | <b>90-day<br/>supply</b>                          | <b>30-day<br/>supply</b>                                              | <b>90-day<br/>supply</b>    | <b>90-day supply</b> |
| <b>Tier 1</b>             | \$10 Co-pay                                                                      | \$25 Co-pay                                       | \$25 Co-pay                                                           | \$75 Co-pay                 | \$25 Co-pay          |
| <b>Tier 2</b>             | \$35 Co-pay                                                                      | \$87.50<br>Co-pay                                 | \$70 Co-pay                                                           | \$210 Co-pay                | \$87.50 Co-pay       |
| <b>Tier 3</b>             | \$70 Co-pay                                                                      | \$175 Co-pay                                      | \$140 Co-pay                                                          | \$420 Co-pay                | \$175 Co-pay         |

**Specialty Drugs:** \$300 Co-pay per 30-day supply. Specialty drugs are high-cost drugs that require special storage of handling and close monitoring of a patient's drug therapy. Specialty drugs are noted on the SummaCare Drug Formulary with an asterisk (\*) and are used to treat medical conditions such as cystic fibrosis and multiple sclerosis. These drugs must be obtained through SummaCare's specialty drug network.

**Special \$0 Co-pay Items:** Under the Affordable Care Act, certain preventive drugs and over-the-counter recommended items/services are required to be covered without cost when prescribed by a health care provider as preventive measures. Examples include:

- Generic fluoride supplements for children up to the age of 6 years old.
- Generic folic acid supplements for women between the ages of 16 and 50.
- Generic aspirin formulations for members between the ages of 45 and 79 (quantity limits apply).
- Generic iron supplements for members ages 6 months to 1 year old.
- Generic oral, vaginal ring and injectable contraceptive products, contraceptive devices, brand formulations of the contraceptive patch (Prior Authorization may be required) and all other brand formulations where a generic alternative is not available (Except for employer groups who qualify for a religious exception as outlined under federal law). An exception for a brand with a generic alternative will be made if the attending Provider recommends a particular brand contraceptive product based on a determination of medical necessity.
- Prescription smoking cessation products; varenicline (up to 180 days in a 365-day period), bupropion (generic only), nicotine nasal spray and inhaler forms (up to 90 days of therapy)

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in a 365-day period).

- Prescription medications tamoxifen and raloxifene when prescribed for preventing breast cancer.
- Select preventive vaccinations, as identified on the formulary; limits may apply.
- Pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy to people who are determined to be at high risk of Human immunodeficiency Virus (HIV) acquisition.