Summary of Benefits

Plan Year January 1, 2023 through December 31, 2023

SummaCare Medicare Sapphire (HMO-POS) (H3660_029)

The SummaCare Medicare Sapphire (HMO-POS) plan is available to residents of the following counties in Ohio: Allen, Ashland, Ashtabula, Auglaize, Carroll, Columbiana, Cuyahoga, Defiance, Fulton, Geauga, Hancock, Henry, Holmes, Huron, Lake, Lorain, Lucas, Mahoning, Medina, Mercer, Ottawa, Portage, Putnam, Seneca, Stark, Summit, Trumbull, Tuscarawas, Van Wert, Wayne and Wood.

SummaCare Medicare Emerald (HMO-POS) (H3660_028)

The SummaCare Medicare Emerald (HMO-POS) plan is available to residents of the following counties in Ohio: Ashtabula, Carroll, Columbiana, Cuyahoga, Geauga, Lake, Lorain, Mahoning, Medina, Portage, Stark, Summit, Trumbull, Tuscarawas and Wayne.

SummaCare is an HMO and HMO-POS plan with a Medicare contract. Enrollment in SummaCare depends on contract renewal. H3660_23_23_M Accepted 09132022

Summary of Benefits

KEY BENEFITS

Things to Know About SummaCare Sapphire and Emerald

What do we cover?

SummaCare Medicare Advantage plans cover everything Original Medicare covers and more. All of our plans include Medicare (Part D) prescription drugs. You can see the complete plan formulary (list of covered drugs) and any restrictions on our website, **summacare.com/medicare**. Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of six "tiers." You will need to use SummaCare's Medicare formulary (list of covered drugs) to locate what tier your drug is in to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document, we discuss the benefit stages that occur: Part D deductible, Initial Coverage Stage, Coverage Gap Stage and Catastrophic Coverage Stage.

Which providers, hospitals and pharmacies can I use?

SummaCare Medicare Sapphire (HMO-POS) and SummaCare Medicare Emerald (HMO-POS) have a network of providers, hospitals and pharmacies. If you use providers that are not in our network, the plan may not pay for these services — except for emergency, urgent and out-of-area renal dialysis services. Out-of-network/non-contracted providers are under no obligation to treat SummaCare members, except in emergency situations. Please call our Member Services number or request an Evidence of Coverage document for more information, including the cost sharing that applies to out-of-network services. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's provider directory on our website, **summacare.com/medicare**, or call us and we will send you a copy of the provider directory. The plans in this Summary of Benefits document also include Visitor/Travel coverage.

Want to learn more?

Visit **summacare.com/medicare** to find more information about our plans. Or, call us at **888.464.8440 (TTY 800.750.0750)**. From October 1 through March 31, a representative is available to take your call from 8 a.m. until 8 p.m., seven days a week. From April 1 through September 30, a representative is available to take your call from 8 a.m. until 8 p.m., Monday – Friday. Outside these hours, you may leave us a message and a representative will return your call the next business day.

To enroll in SummaCare, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area. This document is available in other formats such as Braille, large print or audio. This is a summary document. The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the Evidence of Coverage (EOC). To request the EOC, please call **888.464.8440 (TTY 800.750.0750)**.

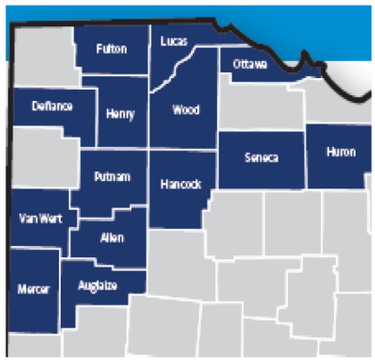
If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **medicare.gov** or order a copy by calling **1.800.MEDICARE (1.800.633.4227)**, 24 hours a day, 7 days a week. TTY users should call **1.877.486.2048**.

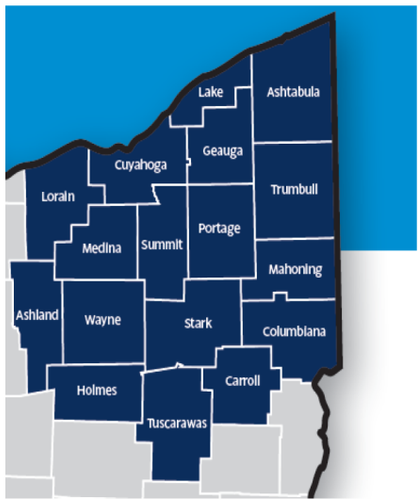
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs and medical expenses. See if you qualify by calling:

- **1.800.MEDICARE (1.800.633.4227)**, 24 hours a day, 7 days a week. TTY/TDD users call **1.877.486.2048**.
- The Social Security Administration at **1.800.772.1213**, Monday – Friday, 7 a.m. to 7 p.m. TTY/TDD users call **1.800.325.0778**.

HMO-POS Plans

With a SummaCare HMO-POS plan, you can receive care from any Medicare-approved provider even if they are not in the SC*Medicare* network. Please note that your out-of-pocket costs may be higher if you select providers outside of our network.

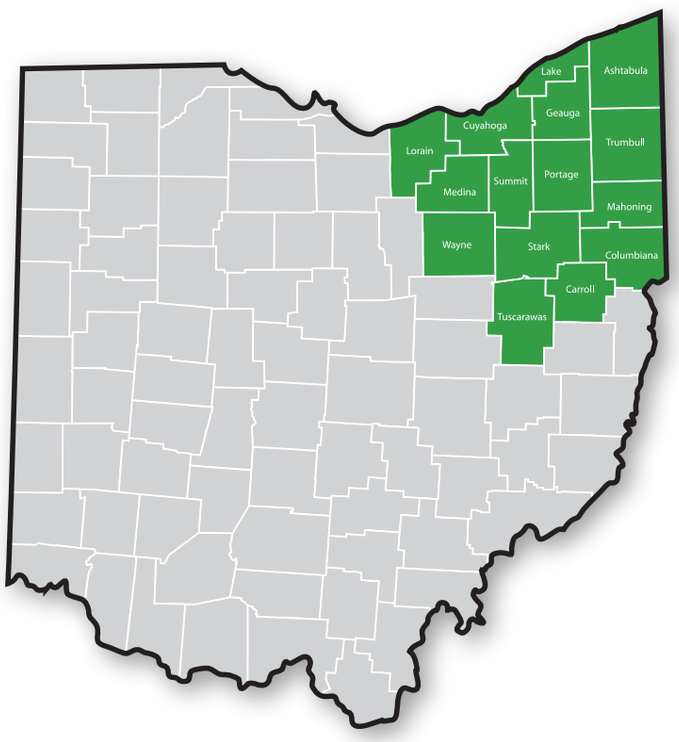




SummaCare Medicare Sapphire (HMO-POS)

$76 Monthly Premium

This plan is available to residents living in the 31 shaded counties on the map to the right. If you live in a county named on the map, you are eligible to enroll in this plan.



SummaCare Medicare Emerald (HMO-POS)

$170 Monthly Premium

This plan is available to residents living in the 15 shaded counties on the map to the left. If you live in a county named on the map, you are eligible to enroll in this plan.

Summary of Benefits

Premiums and Benefits	SummaCare Medicare Sapphire (HMO-POS)	SummaCare Medicare Emerald (HMO-POS)
Monthly Plan Premium	You must continue to pay your Medicare Part B premium.	
	You pay $76	You pay $170
Medical Deductible	You pay nothing.	You pay nothing.
Maximum Out-of-Pocket Responsibility	• Does not include prescription drugs. • Includes copays and other costs for medical services throughout the year.	
	$3,550	$3,400
Inpatient Hospital Coverage	Our plan pays for an unlimited number of days for an inpatient hospital stay.	
	In-network: $240 copay per day for days 1 through 6. You pay nothing after day 6. **Out-of-network:** 25% of the cost for days 1 through 90.	**In-network:** $205 copay per day for days 1 through 5. You pay nothing after day 5. **Out-of-network:** 20% of the cost for days 1 through 90.
Outpatient Hospital Coverage	**Ambulatory surgical center:** **In-network:** $250 copay **Out-of-network:** 20% of the cost	**In-network:** $175 copay **Out-of-network:** 20% of the cost
	Outpatient hospital: **In-network:** $250 copay **Out-of-network:** 20% of the cost	**In-network:** $175 copay **Out-of-network:** 20% of the cost
	Observation services: **In-network:** $250 copay **Out-of-network:** 20% of the cost	**In-network:** $175 copay **Out-of-network:** 20% of the cost
Provider Visits	You are not required to receive authorization before seeking care from most specialists.	
	Primary care provider visit: **In-network:** You pay nothing. **Out-of-network:** $20 copay	**In-network:** You pay nothing. **Out-of-network:** $20 copay
	Specialist visit: **In-network:** $35 copay **Out-of-network:** $55 copay	**In-network:** $0 copay **Out-of-network:** $40 copay

Summary of Benefits

Premiums and Benefits	SummaCare Medicare Sapphire (HMO-POS)	SummaCare Medicare Emerald (HMO-POS)
Preventive Care (e.g., flu vaccines, diabetic screenings)	**Our plan covers many preventive services, including:** • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Annual Wellness Visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screening • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screening and counseling • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines (including flu shots, Hepatitis B shots, pneumococcal shots) • "Welcome to Medicare" preventive visit (one-time)	
	In-network: You pay nothing. **Out-of-network:** $20 copay	**In-network:** You pay nothing. **Out-of-network:** $20 copay
Emergency Care	If you are admitted to the hospital within 24 hours, you do not have to pay the copay. Emergency, urgent care and ambulance services outside of the United States are covered up to a maximum of $25,000 each year. This includes emergency ambulance occurring immediately before a covered emergency visit.	
	In-network: $110 copay per visit **Out-of-network:** $110 copay per visit	**In-network:** $110 copay per visit **Out-of-network:** $110 copay per visit
Urgently Needed Services	Emergency, urgent care and ambulance services outside of the United States are covered up to a maximum of $25,000 each year. This includes emergency ambulance occurring immediately before a covered emergency visit.	
	In-network: $25 copay per visit **Out-of-network:** $25 copay per visit	**In-network:** $25 copay per visit **Out-of-network:** $25 copay per visit

Summary of Benefits

Premiums and Benefits	SummaCare Medicare Sapphire (HMO-POS)	SummaCare Medicare Emerald (HMO-POS)
Diagnostic Services/Labs/ Imaging	The copay is based on where the procedure takes place. You pay a lower copay at a provider's office (office visit copay may apply). You pay a higher copay at all other locations.	
	Diagnostic radiology service (e.g., MRI):	
	In-network: $150 copay **Out-of-network:** 30% of the cost	**In-network:** $100 copay **Out-of-network:** 30% of the cost
	Diagnostic tests and procedures:	
	In-network: $0–$99 copay, depending on the location **Out-of-network:** 30% of the cost	**In-network:** $0–$75 copay, depending on the location **Out-of-network:** 30% of the cost
	Lab services:	
	In-network: $0–$6 copay, depending on the location **Out-of-network:** 30% of the cost	**In-network:** $0–$4 copay, depending on the location **Out-of-network:** 30% of the cost
	Outpatient X-rays:	
	In-network: $0–$99 copay, depending on the location **Out-of-network:** 30% of the cost	**In-network:** $0–$75 copay, depending on the location **Out-of-network:** 30% of the cost
	Therapeutic radiology services (such as radiation treatment for cancer):	
	In-network: 20% of the cost **Out-of-network:** 30% of the cost	**In-network:** 20% of the cost **Out-of-network:** 30% of the cost

Summary of Benefits

Premiums and Benefits	SummaCare Medicare Sapphire (HMO-POS)	SummaCare Medicare Emerald (HMO-POS)
Hearing Services	You are covered for an annual routine hearing exam every year. Services for hearing aids must be received through SummaCare's in-network provider, Amplifon. You receive one year of follow-up care. Risk-free trial of 60 days. Two-year battery support (battery supply or charging station.) Costs for hearing aids do not count towards the out-of-pocket maximum. There is no copay for a hearing aid fitting/evaluation.	
	Diagnostic hearing exam:	
	In-network: $0–$15 copay **Out-of-network:** $55 copay	**In-network:** $0 copay **Out-of-network:** $40 copay
	Supplemental routine hearing exam:	
	In-network: $0 copay **Out-of-network:** $55 copay	**In-network:** $0 copay **Out-of-network:** $40 copay
	Hearing aids: Limit one per ear every year	
	In-network: $395 per hearing aid for Level 1 hearing aids and $695 per hearing aid for Level 2 hearing aids **Out-of-network:** Not covered	**In-network:** $395 per hearing aid for Level 1 hearing aids and $695 per hearing aid for Level 2 hearing aids **Out-of-network:** Not covered
Dental Services	**Preventive dental** covers two cleanings, two exams and one bitewing X-ray per year. Preventive dental also includes full mouth or panoramic X-rays once every five years, periapical X-rays as needed and emergency treatment of dental pain as needed. $0 copay per visit **Comprehensive Dental Services:** • You pay 50% of the allowed amount for fillings, root canals and simple extractions. • You pay 70% of the allowed amount for bridges, crowns and dentures. • $2,000 calendar year maximum for preventive and comprehensive dental services. • Must use Delta Dental of Ohio Medicare Advantage PPO network.	

Summary of Benefits

Premiums and Benefits	SummaCare Medicare Sapphire (HMO-POS)	SummaCare Medicare Emerald (HMO-POS)
Vision Services	You are covered for an annual supplemental routine eye exam each year. Coverage for eyeglasses and/or contact lenses provided after cataract surgery is limited to Medicare-allowed amount for Medicare-covered lenses and frames. In addition to an annual routine eye exam and Medicare-covered eye exams (for diagnosis and treatment for diseases and conditions of the eye), you'll receive an annual amount to use toward the purchase of frames/lenses or contact lenses – with the freedom to visit any vision provider you choose.	
	Diagnostic eye exam:	
	In-network: $0 copay **Out-of-network:** $55 copay	**In-network:** $0 copay **Out-of-network:** $40 copay
	Supplemental routine eye exam:	
	In-network: $0 copay **Out-of-network:** $55 copay	**In-network:** $0 copay **Out-of-network:** $40 copay
	Annual prescription eyewear allowance: Costs for annual eyewear allowance do not count towards the maximum out-of-pocket.	
	$250 allowance	$300 allowance
	Glasses or contact lenses after cataract surgery:	
	In-network: You pay nothing. **Out-of-network:** 30% of the cost	**In-network:** You pay nothing. **Out-of-network:** 30% of the cost
	Yearly glaucoma screening:	
	In-network: You pay nothing. **Out-of-network:** $20 copay	**In-network:** You pay nothing. **Out-of-network:** $20 copay

Summary of Benefits

Premiums and Benefits	SummaCare Medicare Sapphire (HMO-POS)	SummaCare Medicare Emerald (HMO-POS)
Mental Health Services	There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day lifetime limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.	
	Inpatient visit:	
	In-network: $240 copay per day for days 1 through 5. You pay nothing after day 5. **Out-of-network:** 25% of the cost for days 1 through 90.	**In-network:** $205 copay per day for days 1 through 4. You pay nothing after day 4. **Out-of-network:** 20% of the cost for days 1 through 90.
	Outpatient group therapy visit:	
	In-network: $35 copay **Out-of-network:** $55 copay	**In-network:** $0 copay **Out-of-network:** $40 copay
	Outpatient individual therapy visit:	
	In-network: $35 copay **Out-of-network:** $55 copay	**In-network:** $0 copay **Out-of-network:** $0 copay
Skilled Nursing Facility	Our plan covers up to 100 days in a Skilled Nursing Facility. No prior hospital stay required.	
	In-network: You pay nothing per day for days 1 through 20. $188 copay per day for days 21 through 100. **Out-of-network:** $188 copay per day for days 1 through 100.	**In-network:** You pay nothing per day for days 1 through 20. $188 copay per day for days 21 through 100. **Out-of-network:** $188 copay per day for days 1 through 100.

Summary of Benefits

Premiums and Benefits	SummaCare Medicare Sapphire (HMO-POS)	SummaCare Medicare Emerald (HMO-POS)
Physical Therapy	**Cardiac (heart) rehab services:**	
	In-network: You pay nothing. **Out-of-network:** $55 copay	**In-network:** You pay nothing. **Out-of-network:** $40 copay
	Occupational therapy visit:	
	In-network: $35 copay **Out-of-network:** $55 copay	**In-network:** $0 copay **Out-of-network:** $40 copay
	Physical therapy and speech and language therapy visit:	
	In-network: $35 copay **Out-of-network:** $55 copay	**In-network:** $0 copay **Out-of-network:** $40 copay
Ambulance	Emergency, urgent care and ambulance services outside of the United States are covered up to a maximum of $25,000 each year. This includes emergency ambulance occurring immediately before a covered emergency visit.	
	Ground ambulance:	
	In-network: $200 copay **Out-of-network:** $200 copay	**In-network:** $200 copay **Out-of-network:** $200 copay
	Air ambulance:	
	In-network: $200 copay **Out-of-network:** $200 copay	**In-network:** $200 copay **Out-of-network:** $200 copay
Transportation	Routine non-emergent medical transportation services are covered for in-network medical appointments or visits to providers within the plan service area. **Trips must be scheduled through SummaCare's transportation vendor, HOMELINK.**	
	In-network: You pay nothing for 10 one-way trips per calendar year. **Out-of-network:** Not covered	**In-network:** You pay nothing for 12 one-way trips per calendar year. **Out-of-network:** Not covered
Medicare Part B Drugs	**For Part B-covered chemotherapy drugs and other Part B-covered drugs:**	
	In-network: 20% of the cost **Out-of-network:** 30% of the cost	**In-network:** 20% of the cost **Out-of-network:** 30% of the cost

Summary of Benefits

Premiums and Benefits	SummaCare Medicare Sapphire (HMO-POS)	SummaCare Medicare Emerald (HMO-POS)
Acupuncture Services	**General acupuncture:** Includes any combination of acupuncture and therapeutic massage service visits. This is limited to six visits per calendar year.	
	Not covered	**In-network:** $10 copay per visit for any combination of acupuncture and therapeutic massage service visits. This is limited to six visits per calendar year. **Out-of-network:** Not covered
	For chronic lower back pain: Up to a maximum of 20 treatments per year for each Medicare-covered acupuncture treatment visit for chronic low back pain. Visits must be scheduled through HOMELINK.	
	In-network: $35 copay **Out-of-network:** $55 copay	**In-network:** $10 copay **Out-of-network:** $40 copay
Telehealth Services	For each primary care, dermatological, behavioral health and substance abuse telehealth visit provided through Teladoc® or another in-network provider.	
	In-network: $0 copay **Out-of-network:** Not covered	**In-network:** $0 copay **Out-of-network:** Not covered
	For all other in-network telehealth specialist visits:	
	In-network: $20 copay **Out-of-network:** Not covered	**In-network:** $20 copay **Out-of-network:** Not covered

Summary of Benefits

Premiums and Benefits	SummaCare Medicare Sapphire (HMO-POS)	SummaCare Medicare Emerald (HMO-POS)
Part D Prescription Drugs		
Deductible	There is no deductible	There is no deductible
Initial Coverage Stage	You pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail-order pharmacies.	
Tier 1 (Preferred Generic)	**Retail** One Month: $0 Three Month: $0 **Mail-Order** Three Month: $0	**Retail** One Month: $0 Three Month: $0 **Mail-Order** Three Month: $0
Tier 2 (Generic)	**Retail** One Month: $8 Three Month: $20 **Mail-Order** Three Month: $20	**Retail** One Month: $8 Three Month: $20 **Mail-Order** Three Month: $20
Tier 3 (Preferred Brand)	**Retail** One Month: $44 Three Month: $110 **Mail-Order** Three Month: $110	**Retail** One Month: $39 Three Month: $97.50 **Mail-Order** Three Month: $97.50
Tier 4 (Non-preferred Drugs)	**Retail** One Month: $100 Three Month: $300 **Mail-Order** Three Month: $300	**Retail** One Month: $95 Three Month: $285 **Mail-Order** Three Month: $285
Tier 5 (Specialty)	**Retail** One Month: 33% Three Month: N/A **Mail-Order:** N/A Limited to 30-day supply	**Retail** One Month: 33% Three Month: N/A **Mail-Order:** N/A Limited to 30-day supply
Tier 6 (Select care drugs - including vaccines)	**Retail** One Month: $0 Three Month: $0 **Mail-Order:** $0	**Retail** One Month: $0 Three Month: $0 **Mail-Order:** $0

Summary of Benefits

Premiums and Benefits	SummaCare Medicare Sapphire (HMO-POS)	SummaCare Medicare Emerald (HMO-POS)

Part D Prescription Drugs continued

Important message about what you pay for insulin: You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no mater what cost-sharing tier it's on.

If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network facility.

Coverage Gap Stage	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,400, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you. All Tier 1 (Preferred Generic) drugs (retail and mail-order) are covered at a $0 copay if you enter the Coverage Gap. Tier 6 Select Care Drugs and Vaccines are also covered at a $0 copay through the Coverage Gap.
Catastrophic Coverage Stage	Catastrophic Coverage Stage – After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail-order) reach $7,400, you pay the greater of • 5% of the cost, OR • $4.15 copay for generic (including brand drugs treated as generic) and a $10.35 copay for all other drugs.

Summary of Benefits

Premiums and Benefits	SummaCare Medicare Sapphire (HMO-POS)	SummaCare Medicare Emerald (HMO-POS)
Additional Benefits		
PERS (Personal Emergency Response System)	Offered with the Emerald plan only, the Personal Emergency Response System (PERS), through ConnectAmerica, is a mobile device worn as a pendant or around the wrist which offers access to emergency assistance 24/7/365 at the press of a button, whether or not you are at home. The device is GPS-enabled and has optional fall detection capabilities. Coverage includes the mobile device, charging cradle and monthly monitoring in the home.	
	Not covered	$0 copay
Papa Pals	**Hang Out and Help Out.** Papa pairs older adults and families with Papa Pals for companionship and assistance with everyday tasks. Get help around the house, including light housework, a ride to the doctor's office, pharmacy (or anywhere around town), help with errands or simply someone to talk to. Providing support to SummaCare Medicare Advantage members also offers relief and respite to caregivers.	
	Up to 100 hours of assistance	Up to 120 hours of assistance
Visitor/Travel Coverage	SummaCare Medicare members who are visiting the states of Arizona, Florida or Texas receive all plan-covered services through this Visitor/Travel coverage.	
Assist America®	There is no coinsurance, copayment or deductible for emergency travel assistance services provided through Assist America.	
Meal Delivery	You are covered for a maximum of 14 meals (two per day for seven days) following a hospital discharge or for diabetics with a high A1C level.	
Therapeutic Massage	Up to six visits per calendar year for any combination of therapeutic massage services and general acupuncture services performed by in-network providers are covered. The visit limit is combined with the acupuncture benefit. Visits must be scheduled through SummaCare's Acupuncture/ Therapeutic Massage vendor, HOMELINK.	
	Not covered	**In-network:** $10 copay per visit for any combination of acupuncture and therapeutic massage service visits. This is limited to six visits per calendar year. **Out-of-network:** Not covered

Summary of Benefits

Premiums and Benefits	SummaCare Medicare Sapphire (HMO-POS)	SummaCare Medicare Emerald (HMO-POS)
Home Safety Devices	If you have had a diagnosis of any of the following: hip replacement, knee replacement, femur fractures or a diagnosis of falls within the past 12 months, as documented by a provider, you are eligible for home safety devices. A list of covered equipment devices is available at **summacare.com**. Items must be purchased through HOMELINK. Otherwise you will be responsible for the full cost of those items and no payment will be made.	
	In-network: $225 allowance per year **Out-of-network:** Not covered	**In-network:** $250 allowance per year **Out-of-network:** Not covered
Chiropractic Care	**In-network:** $20 copay **Out-of-network:** $55 copay	**In-network:** $0 copay **Out-of-network:** $40 copay
Foot Care (Podiatry Services)	**In-network:** $35 copay **Out-of-network:** $55 copay	**In-network:** $0 copay **Out-of-network:** $40 copay
Home Health Care	**In-network:** You pay nothing. **Out-of-network:** 20% of the cost	**In-network:** You pay nothing. **Out-of-network:** 20% of the cost
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care.

Summary of Benefits

Premiums and Benefits	SummaCare Medicare Sapphire (HMO-POS)	SummaCare Medicare Emerald (HMO-POS)
Medical Equipment/ Supplies	**Durable medical equipment (e.g., wheelchairs, oxygen):**	
	In-network: 20% of the cost **Out-of-network:** 30% of the cost	**In-network:** 20% of the cost **Out-of-network:** 30% of the cost
	Prosthetic devices (e.g., braces, artificial limbs):	
	In-network: 20% of the cost **Out-of-network:** 30% of the cost	**In-network:** 20% of the cost **Out-of-network:** 30% of the cost
	Diabetes monitoring supplies manufactured by Abbott and/or Lifescan:	
	In-network: $0 copay **Out-of-network:** 30% of the cost	**In-network:** $0 copay **Out-of-network:** 30% of the cost
	Diabetes self-management training:	
	In-network: $0 copay **Out-of-network:** $20 copay	**In-network:** $0 copay **Out-of-network:** $20 copay
	Therapeutic shoes or inserts:	
	In-network: 20% of the cost **Out-of-network:** 30% of the cost	**In-network:** 20% of the cost **Out-of-network:** 30% of the cost
Outpatient Substance Abuse	**Group therapy visit:**	
	In-network: $35 copay **Out-of-network:** $55 copay	**In-network:** $0 copay **Out-of-network:** $40 copay
	Individual therapy visit:	
	In-network: $35 copay **Out-of-network:** $55 copay	**In-network:** $0 copay **Out-of-network:** $40 copay

Summary of Benefits

Premiums and Benefits	SummaCare Medicare Sapphire (HMO-POS)	SummaCare Medicare Emerald (HMO-POS)
Opioid Treatment Program Services	Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance-use counseling • Individual and group therapy • Toxicology testing	
	In-network: $0 copay **Out-of-network:** $55 copay	**In-network:** $0 copay **Out-of-network:** $40 copay
Partial Hospitalization	"Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	
	In-network: $40 copay **Out-of-network:** $55 copay	**In-network:** $20 copay **Out-of-network:** $40 copay
Over-the-Counter Items	Coverage includes non-prescription over-the-counter health related items like vitamins, pain relievers, cough and cold medicines and first aid supplies. Refer to your 2023 OTC Product Catalog for complete list of plan-approved OTC items. If you do not use all of your quarterly OTC benefit amount, the remaining balance will not roll over to the next quarter or calendar year.	
	In-network: $40 allowance per quarter **Out-of-network:** Not covered	**In-network:** $55 allowance per quarter **Out-of-network:** Not covered
Renal Dialysis	**In-network:** 20% of the cost **Out-of-network:** 20% of the cost	**In-network:** 20% of the cost **Out-of-network:** 20% of the cost
Health and Wellness Programs and Services	• BrainHQ: Think Faster. Focus Better. Remember More. To address your mind-body health, you'll have access to an online memory fitness program, called BrainHQ, with dozens of brain exercises that have been shown in studies to sharpen cognitive abilities. You can use BrainHQ on your own schedule through any computer, tablet or smartphone with an internet connection. • SilverSneakers® Fitness Program • 24-Hour Nurse Line • QuitCare • Health Manager powered by WebMD® • Enhanced Condition Management Programs	

Summary of Benefits

Premiums and Benefits	SummaCare Medicare Sapphire (HMO-POS)	SummaCare Medicare Emerald (HMO-POS)
Optional Supplemental Dental	If you elect to enroll in this optional supplemental dental plan, you'll pay an additional $35 per month in order to obtain the following additional benefits. You must keep paying your Medicare Part B premium and your SummaCare Medicare plan premium. • If you purchase this optional supplemental dental benefit, the plan will pay a total maximum benefit of $2,000 per benefit year. This includes your preventive and supplemental dental benefits. • Services must be received through Delta Dental's Medicare Advantage PPO or Medicare Advantage Premier network of providers. • Services received from dentists who do NOT participate in Delta Dental's Medicare Advantage PPO or Medicare Advantage Premier network are NOT covered benefits.	
	Basic services: Covered at 50% of the allowed amount for the following services: • Fillings and crown repairs • Root canals • Periodontic services (surgical and non-surgical) • Extractions and oral surgery	
	Major services: Covered at 50% of the allowed amount for the following services: • Major restorative services – crowns and onlays • Relines and repairs – to bridges and dentures	

SummaCare SM

English:
We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at toll-free at **855.416.6441 (TTY 800.750.0750)**. Someone who speaks English can help you. This is a free service.

Español:
Contamos con servicio gratuito de interpretación para responder todas las preguntas que pueda tener sobre nuestros planes de salud o de medicamentos. Para contactarse con un intérprete, llame a nuestra línea totalmente gratuita al número **855.416.6441 (TTY 800.750.0750**). Una persona que hable inglés/español lo ayudará. Este servicio es sin costo.

中文:
我们提供免费口译服务，回答您针对我们的健康或药物计划可能会提出的任何问题。如需翻译，请拨打免费电话 **855.416.6441 (TTY 800.750.0750)**. 会说英语/越南语的人将为您提供帮助。本服务免费。

粵語:
我哋爲你提供免費口譯服務，爲你解答任何醫療保健或醫藥計劃問題。如果你需要口譯員，請撥打免費電話至 **855.416.6441 (TTY 800.750.0750)**. 英語或者越南語人士將會爲你提供服務。呢個係免費服務。

Tagalog:
Mayroon kaming libreng serbisyo mula sa tagapagsalin sa ibang wika para sa inyong mga tanong ukol sa planong pangkalusugan o droga. Tumawag lang sa aming toll-free bilang **855.416.6441 (TTY 800.750.0750**) upang makapanayam ang tagapagsalin sa ibang wika. Matutulungan ka ng sino mang nakakapagsalita ng Ingles/Tagalog. Ito ay walang bayad.

Français:
Nous proposons des services d'interprétation gratuits pour répondre à toutes les questions que vous pouvez avoir sur notre régime d'assurance maladie ou de médicaments. Pour obtenir un interprète, il suffit de nous appeler sans frais au **855.416.6441 (TTY 800.750.0750)**. Une personne qui parle anglais/français peut vous aider. Ce service est gratuit.

Tiếng Việt:
Chúng tôi cung cấp miễn phí dịch vụ phiên dịch để trả lời các thắc mắc của quý vị về chương trình chăm sóc sức khỏe hoặc sử dụng thuốc của chúng tôi. Để nhận dịch vụ phiên dịch miễn phí, vui lòng gọi đến số **855.416.6441 (TTY 800.750.0750)** miễn phí cước. Các phiên dịch viên tiếng Anh/tiếng Việt của chúng tôi luôn sẵn sàng phục vụ quý vị. Đây là dịch vụ hoàn toàn miễn phí.

Deutsch:
Wir bieten kostenlose Dolmetscherdienste, die Ihnen alle Fragen zu unserem Gesundheits- oder Medikamentenplan beantworten kann. Um einen Dolmetscher zu buchen, rufen Sie uns einfach unter der gebührenfreien Nummer **855.416.6441 (TTY 800.750.0750**) an. Jemand, der Englisch/Deutsch spricht, hilft Ihnen. Dieser Dienst ist kostenlos.

한국어:
저희는 저희의 건강 또는 약품 플랜에 대한 질문에 답할 수 있는 무료 통역 서비스를 제공합니다. 통역사를 받으려면 무료 전화 **855.416.6441 (TTY 800.750.0750)** 로 전화하십시오. 영어/한국어를 할 수 있는 사람이 당신을 도울 수 있습니다. 이것은 무료 서비스입니다.

Русский:
Мы используем услуги переводчиков, чтобы ответить на Ваши вопросы о плане медицинского страхования или плане покрытия медицинских препаратов. Чтобы связаться с переводчиком, просто позвоните по бесплатному телефонному номеру **855.416.6441 (TTY 800.750.0750)**. Лицо, говорящее на английском/русском может Вам помочь. Эта услуга бесплатна.

العربية:
نوفر لكم خدمات المترجم الفوري للرد على أي أسئلة قد تطرحونها حول خطتنا بشأن الصحة أو خطتنا الدوائية.
للحصول على مترجم فوري، فقط اتصل بنا على الرقم المجاني: **855-416-6441 (آلة كاتبة مبرقة: 800-750-0750).** يمكن للشخص الذي يتحدث اللغة الإنجليزية / اللغة العربية مساعدتك. هذه الخدمة مجانية.

हिन्दी:
हमारी स्वास्थ्य या दवा योजना के विषय में आपके किसी भी प्रश्न का उत्तर देने के लिए हमारे पास निःशुल्क दुभाषिया सेवाएं हैं। एक दुभाषिया प्राप्त करने के लिए, हमें बस टोल-फ्री पर **855.416.6441 (TTY 800.750.0750)** पर कॉल करें। अंग्रेज़ी/हिंदी बोलने वाला कोई व्यक्ति आपकी सहायता कर सकता है। यह एक निःशुल्क सेवा है।

Italiano:
Siamo dotati di servizi di interpretariato gratuiti per rispondere a qualsiasi domanda tu possa avere sul nostro piano sanitario o farmacologico. Per richiedere un interprete, chiamaci al numero verde **855.416.6441 (TTY 800.750.0750**). Qualcuno che parla Inglese/Italiano saprà aiutarti. E' un servizio gratutito.

Português:
Temos serviços gratuitos de intérprete para responder a quaisquer perguntas que possa ter relativamente ao nosso plano de saúde ou de medicamentos. Para obter a tradução de um intérprete, é só ligar para o número gratuito **855.416.6441 (TTY 800.750.0750**). Uma pessoa que fale Inglês/Português poderá ajudá-lo. Este é um serviço gratuito.

Kreyòl Fransè:
Nou genyen sèvis entèprèt gratis pou reponn nenpòt kesyon ou kapab genyen sou plan sante oswa sou plan medikaman nou an. Pou jwenn yon entèprèt, senpleman rele nou gratis nan **855.416.6441 (TTY 800.750.0750)**. Yon moun ki pale Anglè/Kreyòl Fransè ka ede w. Sa se yon sèvis gratis.

Polski:
Oferujemy bezpłatne usługi tłumacza, aby zapewnić odpowiedzi na wszelkie pytania dotyczące naszego planu opieki zdrowotnej lub lekowego. Aby poprosić o tłumacza, wystarczy zadzwonić do nas pod bezpłatny numer **855.416.6441 (TTY 800.750.0750)**. Pomoże Ci ktoś, kto mówi po angielsku/polsku. Ta usługa jest bezpłatna.

日本語:
弊社の医療・医薬品プランに関するご質問にお答えするため、無料の通訳サービスを実施しております。通訳をご希望の方は、フリーダイヤル 855.416.6441 (TTY 800.750.0750) までお電話してくださいませ。英語/日本語を話せる人が対応します。これは無料サービスです。

SummaCare SM

H3660_23_456NS_C 09012022
SUM-22-60593/CS/TZ/08-22