SUMMIT
HEALTH

Summit Health Medicare Advantage

2023 Summary of Benefits

H2765_1099H276523A_M

2023 Summary of Benefits

This is a summary of drug and health services covered by Summit Health Medicare Advantage plans for January 1, 2023 – December 31, 2023.

Summit Health Plan, Inc. is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

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."

To join a Summit Medicare Advantage plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Oregon: Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler.

If you use providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

This document is available in other formats such as large print or Spanish.

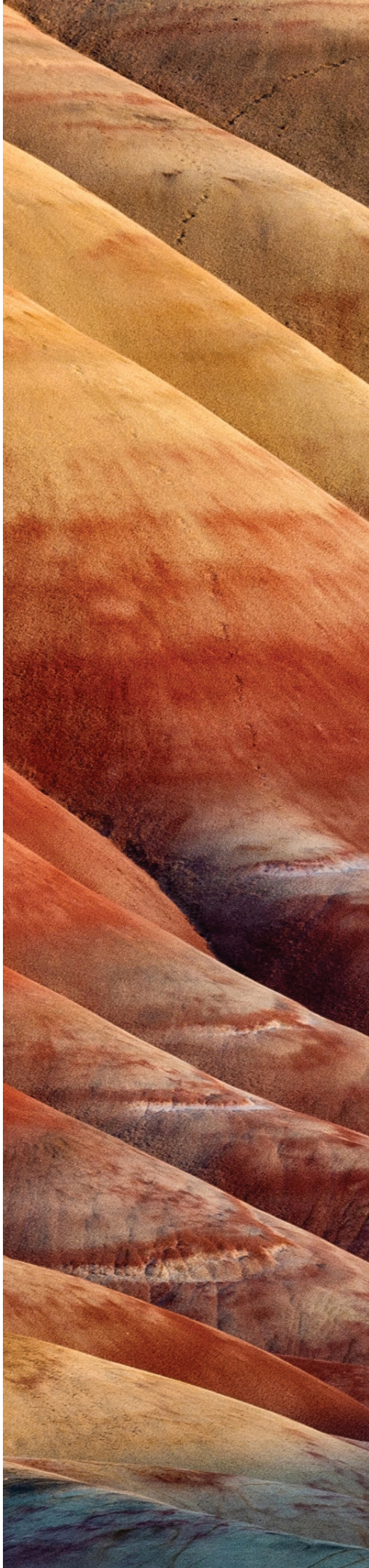
For more information, please call us at 844-827-2355 (TTY Users should call 711) or visit us at yoursummithealth.com. From October 1 to March 31, with the exception of Thanksgiving Day and Christmas Day, you can call us 7 days a week from 7:00 a.m. to 8:00 p.m. Pacific Time. (After March 31, your call will be handled by our automated phone systems, Saturdays, Sundays and holidays.)

Medical benefits

	Summit Health Core (HMO-POS) H2765-001		Summit Health Value + Rx (HMO) H2765-002	
Monthly Premium	$19		$59	
Medical Deductible	$0		$0	
	In-network	Out-of-network	In-network	Out-of-network
Maximum out-of-pocket responsibility *(Does not include prescription drugs)*	$4,990	$4,990 Combined In and Out of Network	$6,990	N/A
Inpatient hospital coverage *(Copay per day 1-5)* *(Authorization rules may apply)*	$350	30%	$374	Not covered
Outpatient hospital coverage (Observation) *(Authorization rules may apply)*	$350	30%	$374	Not covered
Ambulatory surgical center /Outpatient surgery *(Authorization rules may apply)*	$350	30%	$374	Not covered
Doctor Visits Primary care provider *(PCP)*	$10	30%	$0	Not covered
Specialists	$35	30%	$40	Not covered
Preventive care	$0	30%	$0	Not covered
Emergency care	$95		$95	
Urgently needed services	$35		$40	

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

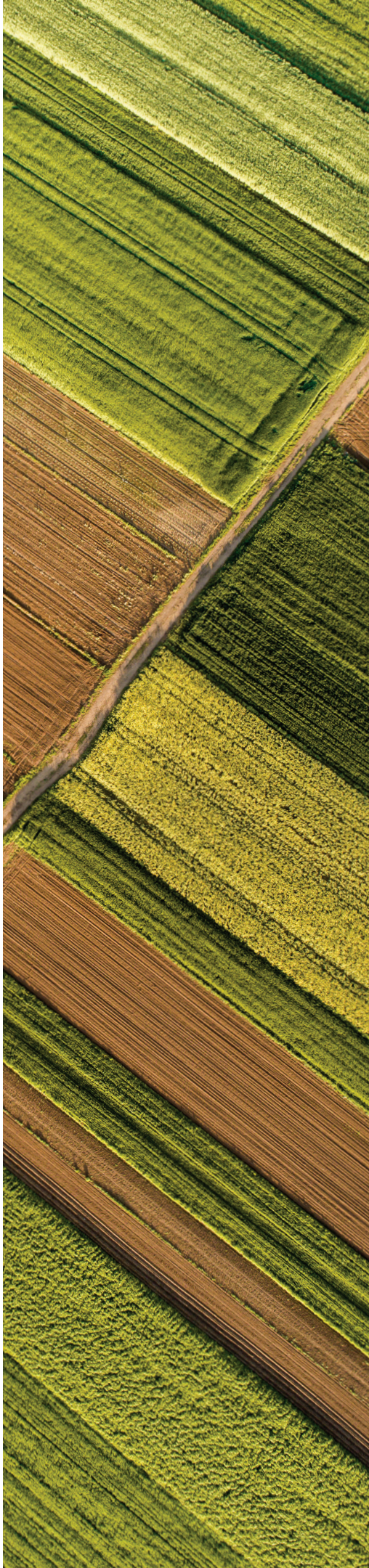
Summit Health Standard + Rx (HMO-POS) H2765-003		Summit Health Premier + Rx (HMO-POS) H2765-004	
$89		$139	
$0		$0	
In-network	Out-of-network	In-network	Out-of-network
$5,880	$8,990 Combined In and Out of Network	$4,850	$7,990 Combined In and Out of Network
$350	50%	$325	30%
$350	50%	$325	30%
$350	50%	$325	30%
$0	50%	$0	30%
$35	50%	$35	30%
$0	50%	$0	30%
$95		$95	
$35		$35	



Medical benefits *(continued)*

	Summit Health Core (HMO-POS) H2765-001		Summit Health Value + Rx (HMO) H2765-002	
	In-network	*Out-of-network*	*In-network*	*Out-of-network*
Diagnostic services/labs/imaging *(Authorization rules may apply)*				
Diagnostic radiology services *(e.g. MRIs, CT scans)*	20%	30%	20%	Not covered
Lab services	$5	30%	$6	Not covered
Outpatient x-rays	20%	30%	20%	Not covered
Hearing services				
Exams to diagnose and treat hearing and balance issues	$35	30%	$40	Not covered
Routine hearing exam for hearing aids	$0	Not covered	$0	Not covered
Hearing aids *(Copay per each aid)*	$699 - $999	Not covered	$699 - $999	Not covered
Dental services				
Medicare-covered	$35	30%	$40	Not covered
Preventive and comprehensive dental *(Total allowance is combined for in and out of network services)*	$0 preventive $750 allowance 20% comprehensive	50% up to $750 allowance	$0 preventive $750 allowance 20% comprehensive	50% up to $750 allowance
Vision services				
Medical vision services *(Medicare-covered)*	$35	30%	$40	Not covered
Routine vision services *(Annual exam & glasses every 2 years)*	$0	50%	$0	50%

Summit Health Standard + Rx (HMO-POS) H2765-003		Summit Health Premier + Rx (HMO-POS) H2765-004	
In-network	*Out-of-network*	*In-network*	*Out-of-network*
20%	50%	20%	30%
$5	50%	$5	30%
20%	50%	20%	30%
$35	50%	$35	30%
$0	Not covered	$0	Not covered
$599-$899	Not covered	$599-$899	Not covered
$35	50%	$35	30%
$0 preventive $1,000 allowance 20% comprehensive	50% up to $1,000 allowance	$0 preventive $1,000 allowance 20% comprehensive	50% up to $1,000 allowance
$35	50%	$35	30%
$0	50%	$0	50%



Medical benefits *(continued)*

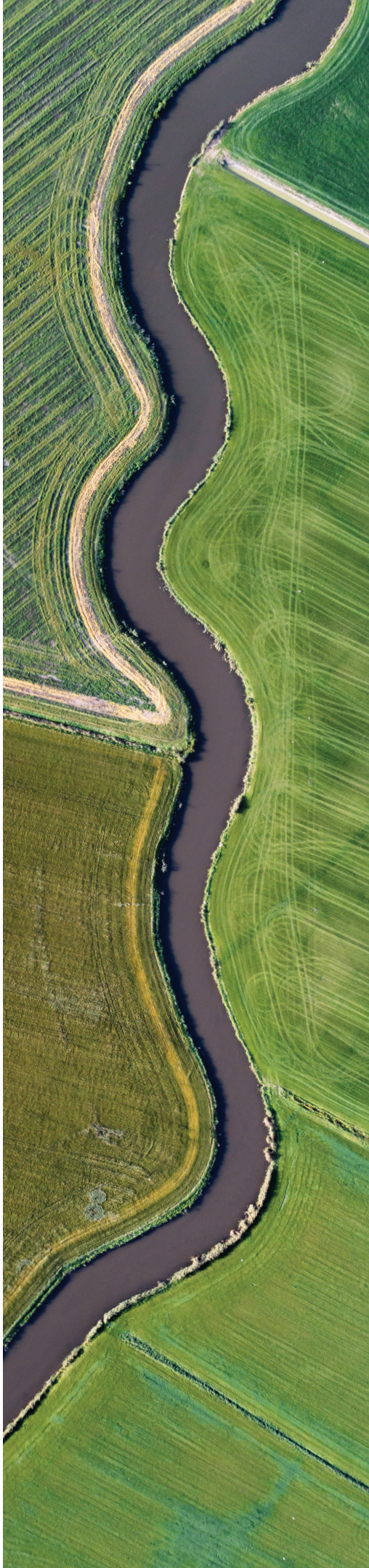
	Summit Health Core (HMO-POS) H2765-001		Summit Health Value + Rx (HMO) H2765-002	
	In-network	*Out-of-network*	*In-network*	*Out-of-network*
Mental Health services				
Outpatient Mental health services *(Outpatient individual or group therapy visit)*	$35	30%	$40	Not covered
Inpatient Mental Health *(Copay per day 1-5)* *(Authorization rules may apply)*	$350	30%	$374	Not covered
Additional services				
Skilled nursing facility *(SNF)* *(Copay per day 21-100)* *(Authorization rules may apply)*	$175	30%	$185	Not covered
Physical therapy	$35	30%	$40	Not covered
Ambulance *(Authorization rules may apply)*	$300		$325	
Transportation	Not covered		Not covered	
Medicare Part B Drugs *(Authorization rules may apply)*	20%	30%	20%	Not covered
Durable medical equipment (DME) *(Authorization rules may apply)*	20%	30%	20%	Not covered
Diabetic monitoring supplies *(Authorization rules may apply)*	$0-20%	30%	$0-20%	Not covered
Alternative care				
Acupuncture for chronic low back pain *(Medicare-Covered)*	$10 (by PCP) $35 (by Specialist)		$0 (by PCP) $40 (by Specialist)	
Chiropractic services *(Medicare-covered)* *(For manipulation of the spine to correct a vertebral subluxation)*	$20	30%	$20	Not Covered
Alternative services *(Embedded Supplemental benefit includes Chiropractic, Acupuncture, and Naturopathic Services up to a combined $500 allowance)*	50% $500 allowance	50%	50% $500 allowance	50%

Summit Health Standard + Rx (HMO-POS) H2765-003		Summit Health Premier + Rx (HMO-POS) H2765-004	
In-network	*Out-of-network*	*In-network*	*Out-of-network*
$35	50%	$35	30%
$350	50%	$325	30%
$175	50%	$170	30%
$35	50%	$35	30%
$300		$275	
Not covered		Not covered	
20%	50%	20%	30%
20%	50%	20%	30%
$0-20%	50%	$0-20%	30%
$0 (by PCP) $35 (by Specialist)		$0 (by PCP) $35 (by Specialist)	
$20	50%	$20	30%
50%	50%	50%	50%
$500 allowance		$500 allowance	

Pharmacy benefits

	Summit Health Core (HMO-POS) H2765-001	Summit Health Value + Rx (HMO) H2765-002	
Outpatient prescription drugs			
Prescription drug deductible	This plan does not include Part D prescription drug coverage.	$235 (waived on tiers 1, 2, & 7)	
Initial coverage stage		30-day supply	90-day supply
Tier 1 *(Preferred generic)*		$4	$10
Tier 2 *(Generic)*		$10	$25
Tier 3 *(Preferred brand)*		$45	$113
Tier 4 *(Non-preferred brand)*		$100	$250
Tier 5 *(Preferred specialty)*		24%	N/A
Tier 6 *(Specialty)*		29%	N/A
Tier 7 *(Vaccine)*		$0	N/A

Summit Health Standard + Rx (HMO-POS) H2765-003		Summit Health Premier + Rx (HMO-POS) H2765-004	
$185 (waived on tiers 1, 2, & 7)		$135 (waived on tiers 1, 2, & 7)	
30-day supply	90-day supply	30-day supply	90-day supply
$4	$10	$4	$10
$10	$25	$10	$25
$45	$113	$45	$113
$100	$250	$100	$250
25%	N/A	25%	N/A
30%	N/A	30%	N/A
$0	N/A	$0	N/A



Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Customer Service for more information.

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 matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Cost sharing changes when you enter another stage of the Part D benefit

You begin in the deductible stage when you fill your first prescription of the year. During this stage, you pay the full cost of your drugs until you have paid the Part D deductible (waived on Tier 1, Tier 2 and Tier 7) for your drugs.

Cost sharing amounts are the same when received from network retail, mail-order, and home infusion pharmacies as well as if you reside in a long-term care facility. You may get up to a 31-day supply of drugs from an out-of-network pharmacy, but you will pay more than you pay at a network pharmacy.

During the coverage gap stage, you pay 25% of the cost for generic or brand name drugs. During the catastrophic coverage stage, you pay the greater of 5% or $4.15 copay for generic drugs and $10.35 copay for all other drugs.

For more information on the different stages, please access your Evidence of Coverage online at yoursummithealth.com or contact Pharmacy Customer Service at 844-827-2355, 7 a.m. to 8 p.m. Pacific Time, seven days a week from October 1 through March 31, with the exception of Thanksgiving Day and Christmas Day. (After March 31, your call will be handled by our automated phone systems Saturdays, Sundays, and holidays.)

This plan includes at no additional cost:

- Access to a 24-hour Nurse Advice Line, 7 days a week, 365 days a year. When you call our Nurse Advice Line, you can speak directly to a registered nurse who will help answer your health-related questions. Your call is always confidential.
- The plan also offers 24/7 on demand diagnosis/ treatment visits with board-certified physicians via text/chat functionality with optional interactive video capabilities.

SUMMIT HEALTH

Multi-Language Insert

Multi-language Interpreter Services

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 844-827-2355. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 844-827-2355. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 844-827-2355。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 844-827-2355。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 844-827-2355. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 844-827-2355. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 844-827-2355 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 844-827-2355. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 844-827-2355 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 844-827-2355. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 844-827-2355. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 844-827-2355 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 844-827-2355. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 844-827-2355. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 844-827-2355. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 844-827-2355. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、844-827-2355 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

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