

SUMMIT HEALTH PLANS

Side-by-Side Plan Comparison • Medical Benefits Snapshot • Rates shown are monthly



PLAN	VALUE PPO	ULTIMATE EPO	ULTIMATE PPO
Network	PPO	EPO	PPO
Deductible (Ind/Fam)	\$0 / \$0	\$0 / \$0	\$0 / \$0
Max Out-of-Pocket (Ind/Fam)	\$4,000 / \$8,000	\$3,500 / \$7,000	\$0 / \$0
Coinsurance	40%	30%	0%
Preventive Care	\$0	\$0	\$0
Primary Care	\$50	\$40	\$0
Specialist	\$75	\$60	\$0
Urgent Care	\$75	\$75	\$0
Labs / X-Ray / Imaging	\$50 basic lab • 40% (limits apply)	30%	\$0
Emergency Room	\$500 + 40% (2/year)	\$500 + 30%	\$0
Hospital / Outpatient Facility	40% (limits apply)	30%	\$0
RX (Generic / Brand / NP / Spec)	Discount card only	\$0 / \$35 / \$75 / \$200	\$0 / \$35 / \$75 / \$200
PREMIUMS (Monthly)	VALUE PPO	ULTIMATE EPO	ULTIMATE PPO
Member Only	\$482.95	\$699.95	\$949.00
Member + Spouse	\$737.08	\$1,549.95	\$1,799.00
Member + Child(ren)	\$756.01	\$1,449.95	\$1,699.00
Family	\$960.42	\$2,149.95	\$2,299.00
DENTAL (Humana Traditional Plus)	Deductible \$50/\$150 • Preventive 100% • Basic 80% • Major 50% • Child Ortho 50% (\$1,500 lifetime) • Unlimited annual max		
VISION (Humana Vision 200)	Exam \$0 • Frames \$200 allowance • Standard lenses \$0 • Contacts \$200 allowance • Exam/Lenses every 12 mo • Frames every 24 mo		

Disclaimer: This document is a summary snapshot of plan benefits and rates for informational purposes only and is subject to change. It does not replace the Schedule of Benefits or official plan documents. For complete details on coverage, limitations, and exclusions, refer to the official plan materials. If this document differs from the plan documents, the plan documents will govern. Prescription benefits for PHCS are a discount program only (not an insured benefit). Pre-certification penalties and service limits may apply.