



## Traditional Option 1

Summit or Advantage

### MEDICAL BENEFITS GRID: WHAT YOU PAY

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

**Percentages indicate your share of PEHP's In-Network Rate.**

	In-Network Provider	Out-of-Network Provider* <i>Balance billing may apply</i>
<b>DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS</b>		
<b>Plan year Deductible</b> <i>Applies to Out-of-Pocket Maximum</i>	Single plans: \$750 Double/family plans: \$750 per person, \$2,250 per family <i>One person cannot meet more than \$750</i>	Single plans: \$1,500 Double/family plans: \$1,500 per person, \$4,500 per family <i>One person cannot meet more than \$1,500</i>
<b>Plan year Out-of-Pocket Maximum**</b>	Single plans: \$4,500 Double/family plans: \$4,500 per person, \$13,200 per family <i>One person cannot meet more than \$4,500</i>	Single plans: \$9,000 Double/family plans: \$9,000 per person, \$27,000 per family <i>One person cannot meet more than \$9,000</i>
<b>ANNUAL PREVENTIVE CARE</b>		
<b>Affordable Care Act Preventive Services</b> <i>See Master Policy for complete list</i>	No charge	Not covered
<b>PROFESSIONAL SERVICES</b>		
<b>PEHP e-Care</b>	<b>Medical:</b> \$10 co-pay per visit	Not applicable
<b>PEHP Value Clinics</b>	\$10 co-pay per visit	Not applicable
<b>Primary Care Visits</b>   <i>Includes office surgeries and inpatient visits</i>	\$30 co-pay per visit	40% after deductible
<b>Specialist Visits</b>   <i>Includes office surgeries and inpatient visits</i>	\$45 co-pay per visit	40% after deductible
<b>Surgery and Anesthesia</b>	20% after deductible	40% after deductible
<b>Emergency Room Specialist Visits</b>	\$45 co-pay per visit	\$45 co-pay per visit
<b>Diagnostic Tests, Labs, X-rays – Minor</b> <i>For each test allowing \$350 or less</i>	No charge	40% after deductible
<b>Diagnostic Tests, Labs, X-rays – Major</b> <i>For each test allowing more than \$350</i>	20% after deductible	40% after deductible
<b>Mental Health and Substance Abuse</b> <i>Requires preauthorization through Blomquist Hale. Failure to preauthorize may result in claim being denied.</i>	<b>Office visit:</b> \$30 co-pay per visit. <b>Outpatient:</b> 20% after deductible. <b>Inpatient:</b> 20% after deductible	40% after deductible
<b>PRESCRIPTION DRUGS</b>		
<b>Pharmacy Deductible</b>	\$100 per person per plan year	
<b>30-day Pharmacy</b> <i>Retail only (up to 90-day supply at participating retail pharmacies)</i>	<b>Tier 1:</b> \$15 co-pay <b>Tier 2:</b> \$35 co-pay after pharmacy deductible <b>Tier 3:</b> \$50 co-pay after pharmacy deductible <b>Tier 4:</b> 30% after pharmacy deductible	
<b>90-day Pharmacy</b> <i>Maintenance only</i>	<b>Tier 1:</b> \$15 co-pay <b>Tier 2:</b> \$70 co-pay after pharmacy deductible <b>Tier 3:</b> \$150 co-pay after pharmacy deductible	

In-network and out-of-network Deductibles accumulate separately. In-network and out-of-network Out-of-Pocket Maximums accumulate separately.

\*Out-of-Network Providers may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or out-of-pocket maximum.

	<b>In-Network Provider</b>	<b>Out-of-Network Provider*</b> <i>Balance billing may apply</i>
<b>OUTPATIENT FACILITY SERVICES</b>		
<b>Outpatient Facility and Ambulatory Surgical Center</b>	20% after deductible	40% after deductible
<b>Urgent Care Facility</b>	\$55 co-pay per visit	40% after deductible
<b>Emergency Room</b> <i>Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied</i>	\$300 co-pay after deductible per visit	\$300 co-pay after deductible per visit
<b>Ambulance (ground or air)</b> <i>Medical emergencies only, as determined by PEHP</i>	20% after deductible	
<b>Diagnostic Tests, Labs, X-rays – Minor</b> <i>For each test allowing \$350 or less, when the only services performed are diagnostic testing</i>	No charge	40% after deductible
<b>Diagnostic Tests, Labs, X-rays – Major</b> <i>For each test allowing more than \$350, when the only services performed are diagnostic testing</i>	20% after deductible	40% after deductible
<b>Chemotherapy, Radiation, and Dialysis</b> <i>Dialysis from out-of-network provider requires preauthorization</i>	20% after deductible	40% after deductible
<b>Physical, Occupational &amp; Speech Therapy</b> <i>Outpatient – up to 20 visits per plan year for each therapy type.</i>	\$45 co-pay after deductible per visit	40% after deductible
<b>INPATIENT FACILITY SERVICES</b>		
<b>Medical &amp; Surgical</b> <i>All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details</i>	20% after deductible	40% after deductible
<b>Skilled Nursing Facility</b> <i>Non-custodial. Up to 60 days per plan year. Requires preauthorization</i>	20% after deductible	40% after deductible
<b>Hospice</b>	20% after deductible	40% after deductible
<b>Rehabilitation</b>   <i>Up to 40 days per plan year. Requires preauthorization</i>	20% after deductible	40% after deductible
<b>Mental Health and Substance Abuse</b> <i>Requires preauthorization through Blomquist Hale. Failure to preauthorize may result in claim being denied.</i>	20% after deductible	40% after deductible
<b>Residential Treatment</b> <i>Requires preauthorization through Blomquist Hale. Failure to preauthorize may result in claim being denied</i>	20% after deductible	Not covered

	In-Network Provider	Out-of-Network Provider* <i>Balance billing may apply</i>
<b>MISCELLANEOUS SERVICES</b>		
<b>Adoption</b>   <i>See Master Policy for benefit limits</i>	20% after deductible, up to \$4,000 per adoption	
<b>Allergy Serum</b>	20%	Not covered
<b>Chiropractic care</b>   <i>Up to 20 visits per plan year</i>	\$20 co-pay per visit	Not covered
<b>Durable Medical Equipment</b> <i>Some DME requires preauthorization. Visit <a href="http://www.pehp.org">www.pehp.org</a> for complete list. See Master Policy for benefit limits</i>	20% after deductible Summit Network: Alpine Home Medical	40% after deductible
<b>Medical Supplies</b> <i>See Master Policy for benefit limits</i>	20% after deductible	40% after deductible
<b>Home Health</b> <i>Requires preauthorization</i>	20% after deductible	40% after deductible
<b>Skilled Nursing</b> <i>Up to 60 visits per plan year. Requires preauthorization</i>	20% after deductible	40% after deductible
<b>Specialty Medications/Injections</b> <i>Office/Outpatient. Medical Deductible applies</i>	20% after deductible	40% after deductible
<b>Infertility Services**</b> <i>Select services only. See Master Policy for details. Maximum of \$1,500 per plan year / \$5,000 per lifetime</i>	50% after deductible	Not covered
<b>Temporomandibular Joint Dysfunction**</b> <i>Non-surgical. Up to \$2,000 lifetime maximum. See Master Policy for details</i>	20% after deductible	Not covered

\*\*Does not apply to the out-of-pocket maximum.