PEHP Health & Benefits

Traditional – Dual Covered

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* *Balance billing may apply*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible	Single plans: $0 Double/family plans: $0	Single plans: $0 Double/family plans: $0
Plan year Out-of-Pocket Maximum	Single plans: $0 Double/family plans: $0	Single plans: $0 Double/family plans: $0
ANNUAL PREVENTIVE CARE		
Affordable Care Act Preventive Services *See Master Policy for complete list*	No charge	Not covered
PROFESSIONAL SERVICES		
PEHP e-Care	**Medical:** No charge	Not applicable
PEHP Value Clinics	**Medical:** No charge	Not applicable
Primary Care Visits | *Includes office surgeries and inpatient visits*	No charge	No charge
Specialist Visits | *Includes office surgeries and inpatient visits*	No charge	No charge
Surgery and Anesthesia	No charge	No charge
Emergency Room Specialist Visits	No charge	No charge
Diagnostic Tests, Labs, X-rays	No charge	No charge
Mental Health and Substance Abuse *Requires preauthorization through Blomquist Hale. Failure to preauthorize may result in claim being denied.*	No charge	No charge
PRESCRIPTION DRUGS		
30-day Pharmacy *Retail only (up to 90-day supply at participating retail pharmacies)*	**Tier 1:** No charge **Tier 2:** No charge **Tier 3:** No charge **Tier 4:** No charge	
90-day Pharmacy *Maintenance only*	**Tier 1:** No charge **Tier 2:** No charge **Tier 3:** No charge	

*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.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	No charge	No charge
Urgent Care Facility	No charge	No charge
Emergency Room *Medical emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	$100 co-pay	$100 co-pay
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	No charge	
Diagnostic Tests, Labs, X-rays	No charge	No charge
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires preauthorization*	No charge	No charge
Physical, Occupational & Speech Therapy *Outpatient – up to 20 visits per plan year for each therapy type.*	No charge	No charge
INPATIENT FACILITY SERVICES		
Medical & Surgical *All out-of-network facilities and some in-network facilities require preathorization.* *See Master Policy for details*	No charge	No charge
Skilled Nursing Facility *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	No charge	No charge
Hospice	No charge	No charge
Rehabilitation | *Up to 40 days per plan year. Requires preauthorization*	No charge	No charge
Mental Health and Substance Abuse *Requires preauthorization through Blomquist Hale. Failure to preauthorize may result in claim being denied.*	No charge	No charge
Residential Treatment *Requires preauthorization through Blomquist Hale. Failure to preauthorize may result in claim being denied*	No charge	Not covered

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption | *See Master Policy for benefit limits*	No charge, up to $4,000 per adoption	
Allergy Serum	No charge	Not covered
Chiropractic care | *Up to 20 visits per plan year*	No charge	Not covered
Durable Medical Equipment *Some DME requires preauthorization. Visit www.pehp.org for complete list.* *See Master Policy for benefit limits*	No charge Summit Network: Alpine Home Medical	No charge
Medical Supplies *See Master Policy for benefit limits*	No charge	No charge
Home Health *Requires preauthorization*	No charge	No charge
Skilled Nursing *Up to 60 visits per plan year. Requires preauthorization*	No charge	No charge
Specialty Medications/Injections *Office/Outpatient. Medical Deductible applies*	No charge	No charge
Infertility Services** *Select services only. See Master Policy for details.* *Maximum of $1,500 per plan year / $5,000 per lifetime*	50%	Not covered
Temporomandibular Joint Dysfunction** *Non-surgical. Up to $2,000 lifetime maximum. See Master Policy for details*	No charge	Not covered

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