



**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.**

	<b>In-Network Provider</b>	<b>Out-of-Network Provider*</b> <i>Balance billing may apply</i>
<b>DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS</b>		
<b>Plan year Deductible</b>	Single plans: \$0 Double/family plans: \$0	Single plans: \$0 Double/family plans: \$0
<b>Plan year Out-of-Pocket Maximum</b> <i>Please refer to the Master Policy for exceptions to the Out-of-Pocket Maximum</i>	Single plans: \$0 Double/family plans: \$0	Single plans: \$0 Double/family plans: \$0
<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> No charge	Not applicable
<b>PEHP Value Clinics</b>	<b>Medical:</b> No charge	Not applicable
<b>Primary Care Visits</b>   <i>Includes office surgeries and inpatient visits</i>	No charge	No charge
<b>Specialist Visits</b>   <i>Includes office surgeries and inpatient visits</i>	No charge	No charge
<b>Surgery and Anesthesia</b>	No charge	No charge
<b>Emergency Room Specialist Visits</b>	No charge	No charge
<b>Diagnostic Tests, Labs, X-rays</b>	No charge	No charge
<b>Mental Health and Substance Abuse</b> <i>Requires preauthorization through Blomquist Hale. Failure to preauthorize may result in claim being denied. Treatment for Autism at in-network providers only, requires preauthorization</i>	No charge	No charge
<b>PRESCRIPTION DRUGS</b>		
<b>30-day Pharmacy</b> <i>Retail only (up to 90-day supply at participating retail pharmacies)</i>	<b>Tier 1:</b> No charge <b>Tier 2:</b> No charge <b>Tier 3:</b> No charge <b>Tier 4:</b> No charge	
<b>90-day Pharmacy</b> <i>Maintenance only</i>	<b>Tier 1:</b> No charge <b>Tier 2:</b> No charge <b>Tier 3:</b> 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.

	<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>	No charge	No charge
<b>Urgent Care Facility</b>	No charge	No charge
<b>Emergency Room</b> <i>Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied</i>	\$100 co-pay	\$100 co-pay
<b>Ambulance (ground or air)</b> <i>Medical emergencies only, as determined by PEHP</i>	No charge	No charge
<b>Diagnostic Tests, Labs, X-rays</b>	No charge	No charge
<b>Chemotherapy, Radiation, and Dialysis</b> <i>Dialysis from out-of-network provider requires preauthorization</i>	No charge	No charge
<b>Physical, Occupational &amp; Speech Therapy</b> <i>Outpatient – up to 20 visits per plan year for each therapy type.</i>	No charge	No charge
<b>Mental Health &amp; Substance Abuse</b> <i>Requires Preauthorization</i>	No charge	No charge
<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>	No charge	No charge
<b>Skilled Nursing Facility</b> <i>Non-custodial. Up to 60 days per plan year. Requires preauthorization</i>	No charge	No charge
<b>Hospice</b>	No charge	No charge
<b>Rehabilitation</b>   <i>Up to 40 days per plan year. Requires preauthorization</i>	No charge	No charge
<b>Mental Health and Substance Abuse</b> <i>Requires preauthorization through Blomquist Hale. Failure to preauthorize may result in claim being denied.</i>	No charge	No charge
<b>Residential Treatment</b> <i>Requires preauthorization through Blomquist Hale. Failure to preauthorize may result in claim being denied</i>	No charge	Not covered

	<b>In-Network Provider</b>	<b>Out-of-Network Provider*</b> <i>Balance billing may apply</i>
<b>MISCELLANEOUS SERVICES</b>		
<b>Adoption / Assisted Reproductive Technology (ART)</b> <i>See Master Policy for benefit limits. ART requires Preauthorization. Excludes multiple-embryo ART implants</i>	No charge after deductible, up to \$4,000 per adoption or up to \$4,000 per single-embryo ART implant	
<b>Allergy Serum</b>	No charge	Not covered
<b>Chiropractic care</b>   <i>Up to 20 visits per plan year</i>	No charge	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>	No charge Summit Network: Alpine Home Medical	No charge
<b>Medical Supplies</b> <i>See Master Policy for benefit limits</i>	No charge	No charge
<b>Home Health</b> <i>Requires preauthorization</i>	No charge	No charge
<b>Skilled Nursing</b> <i>Up to 60 visits per plan year. Requires preauthorization</i>	No charge	No charge
<b>Specialty Medications/Injections</b> <i>Office/Outpatient. Medical Deductible applies</i>	No charge	No charge
<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%	Not covered
<b>Temporomandibular Joint Dysfunction</b> <i>Non-surgical. Up to \$2,000 lifetime maximum. See Master Policy for details</i>	No charge	Not covered