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

In- and Out-of-Network deductibles and 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.

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

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption / Assisted Reproductive Technology (ART) *See Master Policy for benefit limits. ART requires Preauthorization. Excludes multiple-embryo ART implants*	20% after deductible, up to $4,000 per adoption or up to $4,000 per single-embryo ART implant	
Allergy Serum	20%	Not covered
Chiropractic care | *Up to 20 visits per plan year*	$20 co-pay per visit	Not covered
Durable Medical Equipment *Some DME requires preauthorization. Visit www.pehp.org for complete list. See Master Policy for benefit limits*	20% after deductible Summit Network: Alpine Home Medical	40% after deductible
Medical Supplies *See Master Policy for benefit limits*	20% after deductible	40% after deductible
Home Health *Requires preauthorization*	20% after deductible	40% after deductible
Skilled Nursing *Up to 60 visits per plan year. Requires preauthorization*	20% after deductible	40% after deductible
Specialty Medications/Injections *Office/Outpatient. Medical Deductible applies*	20% after deductible	40% after deductible
Infertility Services *Select services only. See Master Policy for details. Maximum of $1,500 per plan year / $5,000 per lifetime*	50% after deductible	Not covered
Temporomandibular Joint Dysfunction *Non-surgical. Up to $2,000 lifetime maximum. See Master Policy for details*	20% after deductible	Not covered