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.

YOU PAY

	In-Network Provider	Out-of-Network Provider*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible	$0 per single, $0 per family	$0 per single, $0 per family
Plan year Out-of-Pocket Maximum	$0 per single, $0 per family	$0 per single, $0 per family
INPATIENT FACILITY SERVICES		
Medical and Surgical | *All-out-of-network facilities and some in-network facilities require preauthorization. See the 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
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgery	No charge	No charge
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	No charge	
Emergency Room *Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will apply*	$100 co-pay	$100 co-pay plus any balance billing above In-Network Rate
Urgent Care Facility	No charge	No charge
Diagnostic Tests, X-rays	No charge	No charge
Chemotherapy, Radiation, and Dialysis	No charge	No charge. Dialysis requires preauthorization
Physical, Occupational & Speech Therapy *Outpatient – up to 20 visits per plan year for each therapy type. Only Speech therapy requires Preauthorization*	No charge	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.

**Please refer to the Master Policy for exceptions to the out-of-pocket maximum.

	In-Network Provider	Out-of-Network Provider*
PROFESSIONAL SERVICES		
Inpatient Physician Office Visits	No charge	No charge
Surgery and Anesthesia	No charge	No charge
PEHP e-Care	**Medical:** No charge. **Mental Health:** No charge. See PEHP Value Options benefits page for details	Not applicable
PEHP Value Clinics	**Medical:** No charge	Not applicable
Primary Care Office Visits and Office Surgeries	No charge	No charge
Specialist Office Visits and Office Surgeries	No charge	No charge
Emergency Room Specialist Visits	No charge	Any balance billing above In-Network Rate
Diagnostic Tests, X-rays	No charge	No charge
Mental Health and Substance Abuse *Requires preauthorization through Blomquist Hale*	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	

	In-Network Provider	Out-of-Network Provider*
MISCELLANEOUS SERVICES		
Adoption | *See Master Policy for limitations*	No charge, plan pays up to $4,000 per adoption	
Affordable Care Act Preventive Services *See Master Policy for complete list*	No charge	Not covered
Allergy Serum	No charge	Not covered
Chiropractic Care | *Up to 20 visits per plan year*	No charge	Not covered
Missing Teeth for Dental Accident or Certain Medical Conditions *Three or more missing teeth at a time, and per lifetime. Requires preauthorization. Dental benefits may apply*	No charge	Any balance billing above In-Network Rate
Durable Medical Equipment, DME *Except for oxygen and Sleep Disorder Equipment, certain DME over $750, rentals that exceed 60 days, or as indicated in Appendix A of the Summary require preauthorization. Maximum limits apply on many items. See Master Policy for benefit limits*	No charge	No charge
Medical Supplies *See the 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
Infertility Services** *Select services only. See Master Policy for details. Maximum of $1,500 per plan year / $5,000 per lifetime*	50% of In-Network Rate	Not covered
Specialty Medications/ Injections *Office/Outpatient*	No charge	No charge
Temporomandibular Joint Dysfunction *Up to $2,000 Lifetime Maximum*	No charge	Not covered