PEHP Health & Benefits

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.

	YOU PAY	
	In-Network Provider	**Out-of-Network Provider***
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan Year Deductible *Applies to out-of-pocket maximum*	$750 per individual, $2,250 per family	$1,500 per individual, $4,500 per family
Plan year Out-of-Pocket Maximum**	$4,500 per individual, $13,200 per family	$9,000 per individual, $27,000 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*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Skilled Nursing Facility | *Non-custodial Up to 60 days per plan year. Requires preauthorization*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Hospice	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Rehabilitation | *Up to 40 days per plan year. Requires preauthorization*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Mental Health and Substance Abuse *Requires preauthorization through Blomquist Hale. Failure to preauthorize may result in claim being denied.*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Residential Treatment *Requires preauthorization through Blomquist Hale. Failure to preauthorize may result in claim being denied.*	20% of In-Network Rate after deductible	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgery	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% of In-Network Rate 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 plus any balance billing above In-Network Rate
Urgent Care Facility	$55 co-pay per visit	40% of In-Network Rate after deductible
Diagnostic Tests, X-rays, Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge	40% of In-Network Rate after deductible
Diagnostic Tests, X-rays, Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Chemotherapy, Radiation, and Dialysis	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible. Dialysis requires preauthorization
Physical, Occupational & Speech Therapy *Outpatient – up to 20 visits per plan year for each therapy type. Only Speech therapy requires preauthorization*	$45 co-pay after deductible per visit	40% of In-Network Rate after 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.

**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	20% of In-Network Rate after deductible per visit	40% of In-Network Rate after deductible
Surgery and Anesthesia	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
PEHP e-Care	**Medical:** $10 co-pay per visit	Not applicable
PEHP Value Clinics	$10 co-pay per visit	Not applicable
Primary Care Office Visits and Office Surgeries	$30 co-pay per visit	40% of In-Network Rate after deductible
Specialist Office Visits and Office Surgeries	$45 co-pay per visit	40% of In-Network Rate after deductible
Emergency Room Specialist Visits	$45 co-pay per visit	$45 co-pay per visit plus any balance billing above In-Network Rate
Diagnostic Tests, X-rays, Minor *For each test allowing $350 or less*	No charge	40% of In-Network Rate after deductible
Diagnostic Tests, X-rays, Major *For each test allowing more than $350*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Mental Health and Substance Abuse *Requires preauthorization through Blomquist Hale. Failure to preauthorize may result in claim being denied.*	**Office visit:** $30 co-pay per visit. **Outpatient:** 20% of In-Network Rate after deductible. **Inpatient:** 20% of In-Network Rate after deductible	40% of In-Network Rate 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-Network Provider	Out-of-Network Provider*
MISCELLANEOUS SERVICES		
Adoption | *See Master Policy for limitations*	20% after deductible, 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	20% of In-Network Rate	Not covered
Chiropractic Care | *Up to 20 visits per plan year*	$20 co-pay per visit	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*	20% of In-Network Rate after deductible	20% of In-Network Rate after deductible, plus 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*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Medical Supplies *See the Master Policy for benefit limits*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Home Health *Requires preauthorization*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Skilled Nursing *Up to 60 visits per plan year. Requires preauthorization*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
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 after deductible	Not covered
Specialty Medications/Injections *Office/Outpatient. Medical Deductible applies*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Temporomandibular Joint Dysfunction *Up to $2,000 Lifetime Maximum*	20% of In-Network Rate after deductible	Not covered