



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

Traditional Option 2

Summit or Advantage

In-Network Provider

Out-of-Network Provider*

DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan Year Deductible <i>Applies to out-of-pocket maximum</i>	\$1,500 per individual, \$4,500 per family	\$3,000 per individual, \$9,000 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 <i>All-out-of-network facilities and some in-network facilities require preauthorization. See the Master Policy for details</i>	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Skilled Nursing Facility <i>Non-custodial. Up to 60 days per plan year. Requires preauthorization</i>	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 <i>Up to 40 days per plan year. Requires preauthorization</i>	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Mental Health and Substance Abuse <i>Requires preauthorization through Blomquist Hale. Failure to preauthorize may result in claim being denied.</i>	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Residential Treatment <i>Requires preauthorization through Blomquist Hale. Failure to preauthorize may result in claim being denied.</i>	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) <i>Medical emergencies only, as determined by PEHP</i>	20% of In-Network Rate after deductible	
Emergency Room <i>Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied</i>	\$200 co-pay after deductible per visit	\$200 co-pay after deductible per visit plus any balance billing above In-Network Rate
Urgent Care Facility	\$40 co-pay per visit	40% of In-Network Rate after deductible
Diagnostic Tests, X-rays, Minor <i>For each test allowing \$350 or less, when the only services performed are diagnostic testing</i>	No charge	40% of In-Network Rate after deductible
Diagnostic Tests, X-rays, Major <i>For each test allowing more than \$350, when the only services performed are diagnostic testing</i>	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 <i>Outpatient – up to 20 visits per plan year for each therapy type. Only Speech therapy requires Preauthorization</i>	\$40 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	\$25 co-pay per visit	40% of In-Network Rate after deductible
Specialist Office Visits and Office Surgeries	\$40 co-pay per visit	40% of In-Network Rate after deductible
Emergency Room Specialist Visits	\$40 co-pay per visit	\$40 co-pay per visit plus any balance billing above In-Network Rate
Diagnostic Tests, X-rays, Minor <i>For each test allowing \$350 or less</i>	No charge	40% of In-Network Rate after deductible
Diagnostic Tests, X-rays, Major <i>For each test allowing more than \$350</i>	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Mental Health and Substance Abuse <i>Requires preauthorization through Blomquist Hale</i>	Office visit: \$25 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	\$150 per person per plan year	
30-day Pharmacy <i>Retail only (up to 90-day supply at participating retail pharmacies)</i>	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 <i>Maintenance only</i>	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 <i>See Master Policy for limitations</i>	20% after deductible, plan pays up to \$4,000 per adoption	
Affordable Care Act Preventive Services <i>See Master Policy for complete list</i>	No charge	Not covered
Allergy Serum	20% of In-Network Rate	Not covered
Chiropractic Care <i>Up to 20 visits per plan year</i>	\$20 co-pay per visit	Not covered
Missing Teeth for Dental Accident or Certain Medical Conditions <i>Three or more missing teeth at a time, and per lifetime. Requires preauthorization. Dental benefits may apply</i>	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 <i>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</i>	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Medical Supplies <i>See the Master Policy for benefit limits</i>	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Home Health <i>Requires preauthorization</i>	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Skilled Nursing <i>Up to 60 visits per plan year. Requires preauthorization</i>	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Infertility Services** <i>Select services only. See Master Policy for details. Maximum of \$1,500 per plan year / \$5,000 per lifetime</i>	50% of In-Network Rate after deductible	Not covered
Specialty Medications/Injections <i>Office/Outpatient. Medical Deductible applies</i>	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Temporomandibular Joint Dysfunction <i>Up to \$2,000 Lifetime Maximum</i>	20% of In-Network Rate after deductible	Not covered