



## Traditional

Summit

### 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* <i>Balance billing may apply</i>
<b>DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS</b>		
<b>Plan year Deductible</b> <i>Applies to Out-of-Pocket Maximum</i>	Single plans: \$1,000 Double/family plans: \$1,000 per person, \$2,000 per family <i>One person cannot meet more than \$1,000</i>	Single plans: \$1,500 Double/family plans: \$1,500 per person, \$3,000 per family <i>One person cannot meet more than \$1,500</i>
<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: \$4,000 Double/family plans: \$4,000 per person, \$8,000 per family <i>One person cannot meet more than \$4,000</i>	Single plans: \$5,500 Double/family plans: \$5,500 per person, \$11,000 per family <i>One person cannot meet more than \$5,500</i>
<b>ANNUAL PREVENTIVE CARE</b>		
<b>Preventive services allowed by Affordable Care Act</b> <i>Annual physical exam, immunizations. See full list at <a href="http://www.pehp.org/preventiveservices">www.pehp.org/preventiveservices</a></i>	No charge	Not covered
<b>PEHP VALUE PROVIDERS</b>		
<b>PEHP Value Providers</b> <i>Cash Back opportunities available. Visit <a href="http://www.pehp.org/valueproviders">www.pehp.org/valueproviders</a></i>	Starting at \$10 co-pay per visit	Not applicable
<b>PROFESSIONAL SERVICES</b>		
<b>Salt Lake County HealthyMe Medical Clinic</b>	\$10 co-pay per visit	Not applicable
<b>Primary Care Visits</b>   <i>Includes office surgeries and inpatient visits</i>	\$25 co-pay per visit after deductible	30% after deductible
<b>Specialist Visits</b>   <i>Includes office surgeries and inpatient visits</i>	\$35 co-pay per visit after deductible	30% after deductible
<b>Surgery and Anesthesia</b>	20% after deductible	30% after deductible
<b>Emergency Room Specialist Visits</b>	\$35 co-pay per visit after deductible	\$35 co-pay per visit after deductible
<b>Diagnostic Tests, Labs, X-rays – Minor</b> <i>For each test allowing \$350 or less</i>	No charge after deductible	30% after deductible
<b>Diagnostic Tests, Labs, X-rays – Major</b> <i>For each test allowing more than \$350</i>	20% after deductible	30% after deductible
<b>Mental Health and Substance Abuse</b> <i>No preauthorization required for outpatient service. Inpatient services require preauthorization</i>	<b>Outpatient:</b> \$35 co-pay after deductible per visit. <b>Inpatient:</b> 20% after deductible	30% after deductible
<b>PRESCRIPTION DRUGS</b>   <i>For Drug Tier info, see the Covered Drug List at <a href="http://www.pehp.org">www.pehp.org</a></i>		
<b>30-day Pharmacy</b> <i>Retail only</i>	<b>Tier 1:</b> \$10 co-pay <b>Tier 2:</b> 25% of discounted cost, \$25 minimum / \$75 maximum <b>Tier 3:</b> 50% of discounted cost, \$50 minimum / \$100 maximum	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. You pay any balance
<b>90-day Pharmacy</b> <i>Maintenance only</i>	<b>Tier 1:</b> \$20 co-pay <b>Tier 2:</b> 25% of discounted cost, \$50 minimum / \$150 maximum <b>Tier 3:</b> 50% of discounted cost, \$100 minimum / \$200 maximum	Not covered

In- and Out-of-Network deductibles and Out-of-Pocket Maximums accrue 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. You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for Out-of-Network Providers.

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	In-Network Provider	Out-of-Network Provider* <i>Balance billing may apply</i>
<b>SPECIALTY DRUGS</b>   For Drug Tier info, see the Covered Drug List at <a href="http://www.pehp.org">www.pehp.org</a>		
<b>Specialty Medications, retail pharmacy</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. \$150 maximum co-pay after deductible <b>Tier B:</b> 20%. \$150 maximum co-pay after deductible	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
<b>Specialty Medications, office/outpatient</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20% after deductible. No maximum co-pay <b>Tier B:</b> 20% after deductible. No maximum co-pay	<b>Tier A:</b> 40% after deductible. No maximum co-pay <b>Tier B:</b> 40% after deductible. No maximum co-pay
<b>Specialty Medications, through Home Health or Accredited</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. \$150 maximum co-pay after deductible <b>Tier B:</b> 20%. \$150 maximum co-pay after deductible <b>Tier C1:</b> 10%. No maximum co-pay after deductible <b>Tier C2:</b> 20%. No maximum co-pay after deductible <b>Tier C3:</b> 30%. No maximum co-pay after deductible	Not covered
<b>OUTPATIENT FACILITY SERVICES</b>		
<b>Outpatient Facility and Ambulatory Surgical Center</b>	20% after deductible	30% after deductible
<b>Urgent Care Facility</b>	\$45 co-pay per visit after deductible	30% after deductible
<b>Emergency Room</b> <i>Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied</i>	\$150 co-pay after deductible per visit	\$150 co-pay after deductible per visit
<b>Ambulance (ground or air)</b> <i>Medical emergencies only, as determined by PEHP</i>	20% after deductible	
<b>Diagnostic Tests, Labs, X-rays – Minor</b> <i>For each test allowing \$350 or less, when the only services performed are diagnostic testing</i>	No charge after deductible	30% after deductible
<b>Diagnostic Tests, Labs, X-rays – Major</b> <i>For each test allowing more than \$350, when the only services performed are diagnostic testing</i>	20% after deductible	30% after deductible
<b>Chemotherapy, Radiation, and Dialysis</b> <i>Dialysis from out-of-network provider requires Preauthorization</i>	20% after deductible	30% after deductible
<b>Physical and Occupational Therapy</b> <i>Outpatient – up to 20 visits per plan year for each therapy type</i>	\$35 co-pay after deductible per visit	30% after deductible
<b>Mental Health &amp; Substance Abuse</b>	20% after deductible	30% after deductible
<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>	20% after deductible	30% after deductible
<b>Skilled Nursing Facility and Residential Treatment</b> <i>Non-custodial. Up to 60 days per plan year. Requires preauthorization</i>	20% after deductible	30% after deductible
<b>Hospice</b>	No charge after deductible	30% after deductible
<b>Rehabilitation</b> <i>Up to 60 days per plan year. Requires preauthorization</i>	20% after deductible	30% after deductible
<b>Mental Health &amp; Substance Abuse</b> <i>Requires Preauthorization</i>	20% after deductible	30% after deductible

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<b>MISCELLANEOUS SERVICES</b>		
<b>Adoption / Assisted Reproductive Technology (ART)</b> <i>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>	20% after deductible	30% after deductible
<b>Autism Spectrum Disorder</b>	\$25 co-pay after deductible	30% after deductible
<b>Bariatric Surgery</b> <i>Requires Preauthorization. Up to one surgery per lifetime.</i>	20% after deductible	Not covered
<b>Chiropractic care</b>   <i>Up to 10 visits per plan year</i>	\$35 co-pay after deductible per visit	\$35 co-pay after deductible per visit
<b>Durable Medical Equipment</b> <i>Some DME requires preauthorization. Visit <a href="http://www.pehp.org">www.pehp.org</a> for complete list.</i>	20% after deductible Summit Network: Alpine Home Medical	30% after deductible
<b>Medical Supplies</b> <i>See Master Policy for benefit limits</i>	20% after deductible	30% after deductible
<b>Home Health/Skilled Nursing</b> <i>Up to 60 visits per plan year. Requires Preauthorization</i>	No charge after deductible	30% after deductible
<b>Injections</b> <i>Includes allergy injections. See above for allergy serum</i>	<b>Under \$50:</b> No charge after deductible <b>Over \$50:</b> 20% after deductible	30% after deductible
<b>Infertility Services</b>   <i>Select services only. See Master Policy for details.</i>	50% after deductible	50% after deductible
<b>Temporomandibular Joint Dysfunction**</b> <i>Non-surgical. Up to \$1,000 lifetime maximum</i>	50% after deductible	50% after deductible

\*\*Does not apply to the out-of-pocket maximum.