



**Silver Plan**  
Summit Exclusive

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.**

	<b>In-Network Provider</b>	<b>Out-of-Network Provider*</b> <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: \$600 Double/family plans: \$600 per person, \$1,200 per family <i>One person cannot meet more than \$600</i>	Single plans: \$1,200 Double/family plans: \$1,200 per person, \$2,400 per family <i>One person cannot meet more than \$1,200</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: \$4,500 Double/family plans: \$4,500 per person, \$6,750 per family <i>One person cannot meet more than \$4,500</i>	Single plans: \$9,000 Double/family plans: \$9,000 per person, \$14,000 per family <i>One person cannot meet more than \$9,000</i>
<b>ANNUAL PREVENTIVE CARE</b>		
<b>Preventive services allowed by Affordable Care Act</b> <i>Wellness Care includes, but not limited to: pap smear, mammogram, prostate screening, gynecological exam, routine physical exam, routine vision exam for children, routine hearing exam for children, immunizations and related laboratory blood tests, colonoscopies. Other preventive services as identified by the Patient Protection and Affordable Care Act (PPACA) will be covered. Including Women's Preventive Care Act</i>	No charge	50% after deductible
<b>PROFESSIONAL SERVICES</b>		
<b>PEHP e-Care / Telemedicine</b>	<b>Medical:</b> \$10 co-pay per visit	Not applicable
<b>PEHP Value Clinics</b>	\$10 co-pay per visit	Not applicable
<b>Primary Care Visits</b>   <i>Includes office surgeries and inpatient visits</i>	30% after deductible per visit	50% after deductible
<b>Specialist Visits</b>   <i>Includes office surgeries and inpatient visits</i>	30% after deductible per visit	50% after deductible
<b>Surgery and Anesthesia</b>	30% after deductible	50% after deductible
<b>Emergency Room Specialist Visits</b>	No charge after deductible	No charge after deductible
<b>Diagnostic Tests, Labs, X-rays – Minor</b> <i>For each test allowing \$350 or less. Preauthorization required on PET scan only</i>	30% after deductible	50% after deductible
<b>Diagnostic Tests, Labs, X-rays – Major</b> <i>For each test allowing more than \$350. Preauthorization required on PET scan only</i>	30% after deductible	50% after deductible
<b>Mental Health and Substance Abuse</b>	30% after deductible	50% after deductible
<b>PRESCRIPTION DRUGS</b>		
<b>30-day Pharmacy</b>   <i>Retail only</i> Customer Service: 800-334-8134 www.optumrx.com Rx Bin: 610011 RxPCN: IRX RxGRP: RXBENEFIT	<b>Generic:</b> \$10 co-pay <b>Brand Formulary:</b> \$30 co-pay <b>Brand/Non-Formulary:</b> \$50 co-pay <b>Specialty:</b> \$100 co-pay	Not covered
<b>90-day Pharmacy</b>   <i>Maintenance only</i> Customer Service: 800-334-8134	<b>Generic:</b> \$10 co-pay <b>Brand Formulary:</b> \$60 co-pay <b>Brand/Non-Formulary:</b> \$150 co-pay	Not covered

In- and Out-of-Network deductibles and Out-of-Pocket Maximums are combined and accumulate together.

\*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.

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	<b>In-Network Provider</b>	<b>Out-of-Network Provider*</b> <i>Balance billing may apply</i>
<b>OUTPATIENT FACILITY SERVICES</b>		
<b>Outpatient Facility and Ambulatory Surgical Center</b>	30% after deductible	50% after deductible
<b>Urgent Care Facility</b>	\$50 co-pay per visit	\$100 co-pay per visit, then plan pays 100% of billed amount
<b>Emergency Room</b> <i>If admitted, inpatient facility benefit will be applied</i>	\$250 co-pay per visit	\$250 co-pay per visit
<b>Ambulance (ground or air)</b>	30% 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. Preauthorization required on PET scan only</i>	30% after deductible	50% 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. Preauthorization required on PET scan only</i>	30% after deductible	50% after deductible
<b>Chemotherapy, Radiation, and Dialysis</b> <i>Requires Preauthorization</i>	30% after deductible	50% after deductible
<b>Physical Therapy</b> <i>Up to 40 visits per plan year.</i>	30% after deductible	50% after deductible
<b>Occupational &amp; Speech Therapy</b> <i>Up to 20 visits per plan year, per therapy class</i>	30% after deductible	50% after deductible
<b>Mental Health &amp; Substance Abuse</b> <i>Requires Preauthorization</i>	30% after deductible	50% after deductible
<b>INPATIENT FACILITY SERVICES</b>		
<b>Medical &amp; Surgical</b> <i>Preauthorization may apply. See Master Policy for details</i>	\$300 co-pay after deductible, then 30%	50% after deductible
<b>Skilled Nursing Facility</b> <i>Requires Preauthorization</i>	30% after deductible	50% after deductible
<b>Hospice</b>	30% after deductible	50% after deductible
<b>Rehabilitation</b> <i>Requires Preauthorization</i>	30% after deductible	50% after deductible
<b>Mental Health &amp; Substance Abuse</b> <i>All services require Preauthorization</i>	\$300 co-pay after deductible, then 30%	50% after deductible
<b>Residential Treatment Facilities</b> <i>Requires Preauthorization</i>	30% after deductible	50% after deductible

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	<b>In-Network Provider</b>	<b>Out-of-Network Provider*</b> <i>Balance billing may apply</i>
<b>MISCELLANEOUS SERVICES</b>		
<b>Adoption</b> <i>See Master Policy for benefit limits</i>	30% after deductible, up to \$4,000 per adoption	
<b>Allergy Serum</b>	30% after deductible	50% after deductible
<b>Chiropractic care</b>   <i>Up to 40 visits per plan year</i>	30% after deductible	Not covered
<b>Durable Medical Equipment</b> <i>Some DME requires preauthorization. Visit <a href="http://www.pehp.org">www.pehp.org</a> for complete list. See Master Policy for benefit limits</i>	30% after deductible Summit Network: Alpine Home Medical	50% after deductible
<b>Medical Supplies</b> <i>See Master Policy for benefit limits</i>	30% after deductible	50% after deductible
<b>Home Health</b> <i>Up to 60 visits per plan year</i>	30% after deductible	50% after deductible
<b>Injections</b> <i>Includes allergy injections. See above for allergy serum</i>	<b>Under \$50:</b> No charge <b>Over \$50:</b> 30% after deductible	50% after deductible
<b>Infertility Services</b>   <i>Includes testing. Does not include treatment. See Master Policy for details</i>	30% after deductible	50% after deductible
<b>Temporomandibular Joint Dysfunction</b> <i>Non-surgical. See Master Policy for details</i>	30% after deductible	50% after deductible
<b>Vision Exam for Adults</b>	30% after deductible	50% after deductible

Failure to obtain prior authorization may result in a penalty of \$200 or denial of benefits.

Any non-allowed or not covered amounts or services are the responsibility of the patient and are not included in the Out-of-Pocket Maximum.

RAPS: services provided by facility based radiologists, anesthesiologists, pathologists, labs, or ER physicians covered under the appropriate facility benefit.

Newborns are automatically covered for 30 days and to continue coverage they must be added to the plan within 30 days of birth.

Dependents Covered to Age 26 Regardless of student or marital status. Coverage terminates the end of the month in which the dependent turns 26.

Timely Filing - Claims must be filed within 12 months from the date the service incurred.

Life Threatening services incurred at a non network provider will be paid as in network.

Rural Area is defined as 30 miles. If covered services are not available in the network within 30 miles the provider will be paid in network.

Out of Country Care will be paid in network for medical emergencies only.