



**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.pehp.org](http://www.pehp.org) or call 1-800-765-7347. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.pehp.org](http://www.pehp.org) or call 1-800-765-7347 to request a copy.

| Important Questions                                                 | Answers                                                                                                                                                                                                                                 | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | \$2,000 single/\$4,000 family                                                                                                                                                                                                           | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.                                                                                                                                                                                                                                                            |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. Preventive care received from <u>network providers</u> is not subject to the <u>deductible</u> .                                                                                                                                   | This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain preventive services without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                       |
| Are there other <u>deductibles</u> for specific services?           | No                                                                                                                                                                                                                                      | You do not have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | \$5,000 individual/\$10,000 family for <u>network providers</u> . No <u>out-of-pocket limit</u> for <u>out-of-network providers</u> . Any one individual may not apply more than \$5,000 toward the family <u>out-of-pocket limit</u> . | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                  |
| What is not included in the <u>out-of-pocket limit</u> ?            | Premiums, balance-billed charges, and healthcare this <u>plan</u> doesn't cover. See Benefits Summary.                                                                                                                                  | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Will you pay less if you use a <u>network provider</u> ?            | Yes. See <a href="http://www.pehp.org">www.pehp.org</a> or call 1-800-765-7347 for a list of <u>network providers</u> .                                                                                                                 | This <u>plan</u> uses a <u>provider</u> network. You will pay less if you use a <u>provider</u> in the plan's network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (a balance bill). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?          | No                                                                                                                                                                                                                                      | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |



All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

| Common Medical Event                                                                                                                                                              | Services You May Need                            | What You Will Pay                                                                                                                                          |                                                                                            | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                   |                                                  | Network Provider<br>(You will pay the least)                                                                                                               | Out-of-Network Provider<br>(You will pay the most)                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| If you visit a health care provider's office or clinic                                                                                                                            | Primary care visit to treat an injury or illness | \$20 co-pay after <u>deductible</u><br>PEHP e-Care: \$10 co-pay per visit after <u>deductible</u><br>PEHP Value Clinics: 20% of AA after <u>deductible</u> | 40% of <u>Allowed Amount</u> (AA) after <u>deductible</u>                                  | *The following services are not covered: charges for after hours or holiday; acupuncture; screening for developmental delay. Infertility charges are payable at 50% of <u>allowed amount</u> after <u>deductible</u> for eligible services, up to \$1,500 per plan year and \$5,000 lifetime.                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                   | Specialist visit                                 | \$35 co-pay after <u>deductible</u>                                                                                                                        | 40% of AA after <u>deductible</u>                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                   | Preventive care/<br>screening/immunization       | No charge                                                                                                                                                  | Not covered                                                                                | *Limited to the Preventive Plus list of preventive services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| If you have a test                                                                                                                                                                | Diagnostic test (x-ray, blood work)              | No charge after <u>deductible</u> if the <u>Allowed Amount</u> is under \$350, 20% of AA/visit after <u>deductible</u> if AA is over \$350                 | 40% of AA after <u>deductible</u>                                                          | *Qualifying adult members age 18 and up may receive one facility-based sleep study for obstructive sleep apnea in a hospital in a three-year period, <u>Pre-authorization</u> required. Additional attended sleep studies for adults must be performed at an office or an office-based clinic, but not a hospital or clinic whose allowed amount is based off a percentage of billed.<br>*Infertility services are payable at 50% of AA after <u>deductible</u> for eligible services, up to \$1,500 per plan year and \$5,000 lifetime.<br>*Genetic testing requires <u>pre-authorization</u> .<br>*Some scans require <u>pre-authorization</u> . |
|                                                                                                                                                                                   | Imaging (CT/PET scans, MRIs)                     | No charge after <u>deductible</u> if the AA is under \$350, 20% of AA/visit after <u>deductible</u> if AA is over \$350                                    | 40% of AA after <u>deductible</u>                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| If you need drugs to treat your illness or condition<br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.pehp.org">www.pehp.org</a> . | Generic drugs (Tier 1)                           | \$5 co-pay after <u>deductible</u> /retail                                                                                                                 | The preferred co-pay after <u>deductible</u> plus the difference above the discounted cost | *PEHP formulary must be used. Retail and mail-order prescriptions not refillable until 75% of the total prescription supply within the last 180 days is used; some drugs require step therapy and/or <u>pre-authorization</u> . Enteral formula requires <u>pre-authorization</u> . No coverage for: non-FDA approved drugs; vitamins, minerals, food supplements, homeopathic medicines, and nutritional supplements; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication.                                                                                 |
|                                                                                                                                                                                   | Preferred brand drugs (Tier 2)                   | 20% of discounted cost after <u>deductible</u> /retail, \$25 minimum / \$75 maximum                                                                        | The preferred co-pay after <u>deductible</u> plus the difference above the discounted cost |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                   | Non-preferred brand drugs (Tier 3)               | 35% of discounted cost after <u>deductible</u> /retail, \$50 minimum / \$100 maximum                                                                       | The preferred co-pay after <u>deductible</u> plus the difference above the discounted cost |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                   | Specialty drugs (Tier 4)                         | Medical - 20% of AA after <u>deductible</u> for Tier A drugs, 30% of AA after <u>deductible</u> for Tier B drugs                                           | Tier A 40% of AA after <u>deductible</u><br>Tier B 50% of AA after <u>deductible</u>       | *PEHP uses the specialty pharmacy Accredo and Home Health Providers for some specialty drugs; <u>pre-authorization</u> may be required. Using Accredo may reduce your cost.                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |



All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

| Common Medical Event                                                   | Services You May Need                          | What You Will Pay                                                                                                               |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|------------------------------------------------------------------------|------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                        |                                                | Network Provider<br>(You will pay the least)                                                                                    | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| If you have outpatient surgery                                         | Facility fee (e.g., ambulatory surgery center) | \$50 co-pay after <u>deductible</u>                                                                                             | 40% of AA after <u>deductible</u>                  | *No coverage for: cosmetic surgery; bariatric surgery. Payable at 50% of AA after <u>deductible</u> when medically necessary: breast reduction; blepharoplasty; infertility surgery for eligible services, up to \$1,500 per plan year and \$5,000 lifetime; sclerotherapy of varicose veins; micro-phlebectomy. Spinal cord stimulators requires <u>pre-authorization</u> .                                                                                                                                        |
|                                                                        | Physician/surgeon fees                         | 20% of AA after <u>deductible</u>                                                                                               | 40% of AA after <u>deductible</u>                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| If you need immediate medical attention                                | <u>Emergency room care</u>                     | 20% of AA after <u>deductible</u> /visit                                                                                        | 20% of AA after <u>deductible</u> /visit           | ----None----                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                        | <u>Emergency medical transportation</u>        | 20% of AA after <u>deductible</u>                                                                                               | 20% of AA after <u>deductible</u>                  | *Ambulance charges for the convenience of the patient or family are not covered. Air ambulance covered only in life-threatening emergencies and only to the nearest facility where proper medical care is available.                                                                                                                                                                                                                                                                                                |
|                                                                        | <u>Urgent care</u>                             | \$35 co-pay after <u>deductible</u> /visit                                                                                      | 40% of AA after <u>deductible</u> /visit           | ----None----                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| If you have a hospital stay                                            | Facility fee (e.g., hospital room)             | 20% of AA after <u>deductible</u>                                                                                               | 40% of AA after <u>deductible</u>                  | *Take home medication from a hospital or other facility unless legally required and approved by PEHP. Inpatient mental health/sub-stance abuse, skilled nursing facilities, inpatient rehab facilities, out-of network inpatient, out-of-state inpatient and some in-network facilities require <u>pre-authorization</u> .                                                                                                                                                                                          |
|                                                                        | Physician/surgeon fee                          | 20% of AA after <u>deductible</u>                                                                                               | 40% of AA after <u>deductible</u>                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| If you have mental health, behavioral health, or substance abuse needs | Outpatient services                            | Psychiatrist: \$30 co-pay after <u>deductible</u> /visit;<br>Psychologist/LCSW/APRN: \$20 co-pay after <u>deductible</u> /visit | 40% of AA after <u>deductible</u>                  | *No coverage for: milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, situational disturbances. Residential treatment programs require preauthorization and 60 day limit applies. Some of these services may be covered through your employer's Employee Assistance Program or Life Assistance Counseling. Inpatient: requires <u>pre-authorization</u> . |
|                                                                        | Inpatient services                             | 20% of AA after <u>deductible</u>                                                                                               | 40% of AA after <u>deductible</u>                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| If you are pregnant                                                    | Office visits                                  | 20% of AA after <u>deductible</u>                                                                                               | 40% of AA after <u>deductible</u>                  | ----None----                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                        | Childbirth/delivery professional services      | 20% of AA after <u>deductible</u>                                                                                               | 40% of AA after <u>deductible</u>                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                        | Childbirth/delivery facility services          | 20% of AA after <u>deductible</u>                                                                                               | 40% of AA after <u>deductible</u>                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |



All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

| Common Medical Event                                           | Services You May Need            | What You Will Pay                                                                               |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                |
|----------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                  | Network Provider<br>(You will pay the least)                                                    | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                       |
| If you need help recovering or have other special health needs | <u>Home health care</u>          | 20% of AA after <u>deductible</u>                                                               | 40% of AA after <u>deductible</u>                  | *Requires <u>pre-authorization</u> . No coverage for custodial care. Maximum of 60 visits per plan year.                                                                                                                                                                                                                                              |
|                                                                | <u>Rehabilitation services</u>   | Inpatient: 20% of AA after <u>deductible</u><br>Outpatient: \$20 co-pay after deductible/visit. | 40% of AA after <u>deductible</u>                  | *Outpatient Physical Therapy (PT) /Occupational Therapy (OT) /Speech Therapy (ST) require <u>pre-authorization</u> after 20 visits per plan year for each therapy type. Maintenance therapy and therapy for developmental delay are not covered. Inpatient rehabilitation is limited to 30 days per plan year and requires <u>pre-authorization</u> . |
|                                                                | <u>Habilitation services</u>     | Inpatient: 20% of AA after <u>deductible</u><br>Outpatient: \$20 co-pay after deductible/visit. | 40% of AA after <u>deductible</u>                  |                                                                                                                                                                                                                                                                                                                                                       |
|                                                                | <u>Skilled nursing care</u>      | 20% of AA after <u>deductible</u>                                                               | 40% of AA after <u>deductible</u>                  |                                                                                                                                                                                                                                                                                                                                                       |
|                                                                | <u>Durable medical equipment</u> | 20% of AA after <u>deductible</u>                                                               | 40% of AA after <u>deductible</u>                  | *No coverage for custodial care. Maximum of 60 days per illness per plan year.<br>*Sleep disorder supplies are limited to \$325 in a plan year. One oral sleep appliance is covered every 5 years. Certain equipment requires <u>pre-authorization</u> .                                                                                              |
|                                                                | <u>Hospice service</u>           | 20% of AA after <u>deductible</u>                                                               | 40% of AA after <u>deductible</u>                  | ----None----                                                                                                                                                                                                                                                                                                                                          |
| If your child needs dental or eye care                         | Children's eye exam              | No charge                                                                                       | Not covered                                        | *One routine exam per plan year.                                                                                                                                                                                                                                                                                                                      |
|                                                                | Children's glasses               | Not covered                                                                                     | Not covered                                        | ----None----                                                                                                                                                                                                                                                                                                                                          |
|                                                                | Children's dental check-up       | Not covered                                                                                     | Not covered                                        | ----None----                                                                                                                                                                                                                                                                                                                                          |

Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .) |                                                                        |                                                                                                                                                                                                                                                          |                                                                                                    |                                                                                                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| • Acupuncture                                                                                                                                  | • Complications from any non-covered services, devices, or medications | • Glasses                                                                                                                                                                                                                                                | • Non-emergency care when traveling outside the U.S.                                               | • Prescription medications not on the PEHP formulary; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication; take-home medications |
| • Ambulance... charges for the convenience of the patient or family; air ambulance for non-life-threatening situations                         | • Cosmetic surgery                                                     | • Mental Health — milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, situational disturbances | • Nursing — private duty                                                                           | • Weight-loss programs                                                                                                                                                                                                  |
| • Bariatric surgery                                                                                                                            | • Custodial care and/or maintenance therapy                            |                                                                                                                                                                                                                                                          | • Nutritional supplements, including — vitamins, minerals, food supplements, homeopathic medicines |                                                                                                                                                                                                                         |
| • Charges for which a third party, auto insurance, or worker's compensation plan are responsible                                               | • Dental care (Adults or children)                                     |                                                                                                                                                                                                                                                          | • Office visits — charges for after hours or holiday                                               |                                                                                                                                                                                                                         |
|                                                                                                                                                | • Developmental delay — testing and treatment                          |                                                                                                                                                                                                                                                          |                                                                                                    |                                                                                                                                                                                                                         |
|                                                                                                                                                | • Equipment, used or from unlicensed providers                         |                                                                                                                                                                                                                                                          |                                                                                                    |                                                                                                                                                                                                                         |
|                                                                                                                                                | • Foot care — routine                                                  |                                                                                                                                                                                                                                                          |                                                                                                    |                                                                                                                                                                                                                         |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.) |                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| • Coverage provided outside the U.S.                                                                                                | • Routine eye care (Adults and children, exams only) |
| • Long-term care                                                                                                                    |                                                      |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596. For more information on your rights to continue coverage, contact the plan at 1-800-765-7347.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: [www.pehp.org](http://www.pehp.org) or 1-800-765-7347.

**Does this Coverage Provide Minimum Essential Coverage? Yes.**

If you don't have Minimum Essential Coverage for a month under this plan or under other coverage, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this Coverage Meet the Minimum Value Standard? Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-765-7347 (TTY: 711).

-----To see examples of how this plan might cover costs for a sample medical situation, see the next page.-----

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby  
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible \$2,000
- Specialist copayment \$35
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
Diagnostic tests (ultrasounds and blood work)  
Specialist visit (anesthesia)

|                                 |         |
|---------------------------------|---------|
| Total Example Cost              | \$7,600 |
| In this example, Peg would pay: |         |
| Cost sharing                    |         |
| Deductibles                     | \$2,000 |
| Copayments                      | \$0     |
| Coinsurance                     | \$1,020 |
| What isn’t covered              |         |
| Limits or exclusions            | \$0     |
| The total Peg would pay is      | \$3,020 |

Managing Joe’s type 2 Diabetes  
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible \$2,000
- Specialist copayment \$35
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Primary care physician visits (including disease education)  
Diagnostic tests (blood work)  
Prescription drugs  
Durable medical equipment (glucose meter)

|                                 |         |
|---------------------------------|---------|
| Total Example Cost              | \$5,500 |
| In this example, Joe would pay: |         |
| Cost sharing                    |         |
| Deductibles                     | \$2,000 |
| Copayments                      | \$0     |
| Coinsurance                     | \$700   |
| What isn’t covered              |         |
| Limits or exclusions            | \$0     |
| The total Joe would pay is      | \$2,700 |

Mia’s Simple Fracture  
(in-network emergency room visit and follow up care)

- The plan’s overall deductible \$2,000
- Specialist copayment \$35
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)  
Diagnostic tests (x-ray)  
Durable medical equipment (crutches)  
Rehabilitation services (physical therapy)

|                                 |         |
|---------------------------------|---------|
| Total Example Cost              | \$2,500 |
| In this example, Mia would pay: |         |
| Cost sharing                    |         |
| Deductibles                     | \$2,000 |
| Copayments                      | \$0     |
| Coinsurance                     | \$100   |
| What isn’t covered              |         |
| Limits or exclusions            | \$0     |
| The total Mia would pay is      | \$2,100 |

Note: These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact PEHP Healthy Utah, 801-366-7300.

The plan would be responsible for the other costs of these EXAMPLE covered services.