PEHP Health & Benefits

Traditional Plus

Summit & 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.

Percentages indicate your share of PEHP's In-Network Rate.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $1,200 Double/family plans: $1,200 per person, $3,600 per family *One person cannot meet more than $1,200*	
Plan year Out-of-Pocket Maximum *Includes Medical Deductible. Please refer to the Master Policy for exceptions to the out-of-pocket maximum.*	Single plans: $4,000 Double/family plans: $4,000 per person, $8,000 per family *One person cannot meet more than $4,000*	
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations. See full list at www.pehp.org/preventiveservices*	No charge	40% after deductible
PROFESSIONAL SERVICES		
PEHP e-Care	**Medical:** $10 co-pay per visit	Not applicable
PEHP Value Clinics	$10 co-pay per visit	Not applicable
Primary Care Visits | *Includes office surgeries and inpatient visits*	$30 co-pay per visit	40% after deductible
Specialist Visits | *Includes office surgeries and inpatient visits*	$50 co-pay per visit	40% after deductible
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	$50 co-pay per visit	$50 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less*	No charge	40% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	$30 co-pay after deductible per service	40% after deductible
Mental Health and Substance Abuse *Treatment for Autism requires preauthorization*	**Outpatient:** $30 co-pay per visit for psychiatrist; $20 co-pay per visit for psychologist/LCSW/APRN. **Inpatient:** 20% after deductible	40% after deductible
PRESCRIPTION DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	**Tier 1:** $5 co-pay **Tier 2:** 20% of discounted cost, $25 minimum / $75 maximum **Tier 3:** 35% 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
90-day Pharmacy *Maintenance only*	**Tier 1:** $10 co-pay **Tier 2:** 20% of discounted cost, $50 minimum / $150 maximum **Tier 3:** 35% of discounted cost, $100 minimum / $200 maximum	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. You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for Out-of-Network Providers.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
SPECIALTY DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% after deductible. No maximum co-pay **Tier B:** 30% after deductible. No maximum co-pay	**Tier A:** 40% after deductible. No maximum co-pay **Tier B:** 50% after deductible. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C1:** 10%. No maximum co-pay **Tier C2:** 20%. No maximum co-pay **Tier C3:** 30%. No maximum co-pay	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	$50 co-pay after deductible per visit	40% after deductible
Urgent Care Facility	$35 co-pay per visit	40% after deductible
Emergency Room *Medical emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	$150 co-pay after deductible per visit	$150 co-pay after deductible per visit
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible	
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge	40% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	20% after deductible	40% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible	40% after deductible
Physical, Speech, and Occupational Therapy *Outpatient – requires preauthorization after 20 visits per plan year for each therapy type.*	$30 co-pay per visit	40% after deductible
Mental Health & Substance Abuse	$30 co-pay after deductible per visit	40% after deductible
INPATIENT FACILITY SERVICES		
Medical & Surgical *All out-of-network facilities and some in-network facilities require preathorization.* *See Master Policy for details*	20% after deductible	40% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible	40% after deductible
Hospice	20% after deductible	40% after deductible
Rehabilitation *Up to 30 days per plan year. Requires preauthorization*	20% after deductible	40% after deductible
Mental Health & Substance Abuse *All services require Preauthorization.*	20% after deductible	40% after deductible

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption | *See Master Policy for benefit limits*	No charge, plan pays up to $2,500 per adoption	
Allergy Serum	$55 co-pay per visit	40% after deductible
Chiropractic Care *Requires preauthorization after 20 visits, up to 40 visits per plan year*	$30 co-pay per visit	Not covered
Durable Medical Equipment *Some DME requires preauthorization. Visit www.pehp.org for complete list.* *See Master Policy for benefit limits*	20% after deductible Summit Network: Alpine Home Medical	40% after deductible
Hearing Aids *Requires preauthorization*	20% after deductible	40% after deductible
Medical Supplies *See Master Policy for benefit limits*	20% after deductible	40% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	20% after deductible	40% after deductible
Injections *Includes allergy injections. See above for allergy serum.* *Requires preauthorization if over $750*	**Under $50:** No charge **Over $50:** 20% after deductible	40% after deductible
Infertility Services** *Up to $1,500 per plan year. Up to $5,000 Lifetime Maximum.* *Select services only. See Master Policy for details*	50% after deductible	Not covered
Orthotics *Up to two pair per plan year*	20% after deductible	40% after deductible
Preventive Eye Exam *Limited to one per plan year*	No charge	Not covered
Temporomandibular Joint Dysfunction** *Non-surgical. Up to $2,000 lifetime maximum. See Master Policy for details*	50% after deductible	50% after deductible

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

PEHP Health & Benefits

Traditional In-Network Only

Summit & 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.

Percentages indicate your share of PEHP's In-Network Rate.

	In-Network Provider
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS	
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $1,200 Double/family plans: $1,200 per person, $3,600 per family *One person cannot meet more than $1,200*
Plan year Out-of-Pocket Maximum *Includes Medical Deductible. Please refer to the Master Policy for exceptions to the out-of-pocket maximum.*	Single plans: $4,000 Double/family plans: $4,000 per person, $8,000 per family *One person cannot meet more than $4,000*
ANNUAL PREVENTIVE CARE	
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge
PROFESSIONAL SERVICES	
PEHP e-Care	**Medical:** $10 co-pay per visit
PEHP Value Clinics	$10 co-pay per visit
Primary Care Visits | *Includes office surgeries and inpatient visits*	$30 co-pay per visit
Specialist Visits | *Includes office surgeries and inpatient visits*	$50 co-pay per visit
Surgery and Anesthesia	20% after deductible
Emergency Room Specialist Visits	$50 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less*	No charge
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	$30 co-pay after deductible per service
Mental Health and Substance Abuse *Treatment for Autism requires preauthorization*	**Outpatient:** $30 co-pay per visit for psychiatrist; $20 co-pay per visit for psychologist/LCSW/APRN. **Inpatient:** 20% after mental health deductible
PRESCRIPTION DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***	
30-day Pharmacy *Retail only*	**Tier 1:** $5 co-pay **Tier 2:** 20% of discounted cost, $25 minimum / $75 maximum **Tier 3:** 35% of discounted cost, $50 minimum / $100 maximum
90-day Pharmacy *Maintenance only*	**Tier 1:** $10 co-pay **Tier 2:** 20% of discounted cost, $50 minimum / $150 maximum **Tier 3:** 35% of discounted cost, $100 minimum / $200 maximum

	In-Network Provider
SPECIALTY DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***	
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% after deductible. No maximum co-pay **Tier B:** 30% after deductible. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C1:** 10%. No maximum co-pay **Tier C2:** 20%. No maximum co-pay **Tier C3:** 30%. No maximum co-pay
OUTPATIENT FACILITY SERVICES	
Outpatient Facility and Ambulatory Surgical Center	$50 co-pay after deductible per visit
Urgent Care Facility	$35 co-pay per visit
Emergency Room *Medical emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	$150 co-pay after deductible per visit
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	$30 co-pay after deductible per service
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible
Physical, Speech, and Occupational Therapy *Outpatient – requires preauthorization after 20 visits per plan year for each therapy type.*	$30 co-pay per visit
Mental Health & Substance Abuse	$50 co-pay after deductible per visit
INPATIENT FACILITY SERVICES	
Medical & Surgical *All out-of-network facilities and some in-network facilities require preathorization. See Master Policy for details*	20% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible
Hospice	20% after deductible
Rehabilitation *Up to 30 days per plan year. Requires preauthorization*	20% after deductible
Mental Health & Substance Abuse *All services require Preauthorization.*	20% after deductible

	In-Network Provider
MISCELLANEOUS SERVICES	
Adoption | *See Master Policy for benefit limits*	No charge, plan pays up to $2,500 per adoption
Allergy Serum	$55 co-pay per visit
Chiropractic Care *Requires preauthorization after 20 visits, up to 40 visits per plan year*	$30 co-pay per visit
Durable Medical Equipment *Some DME requires preauthorization. Visit www.pehp.org for complete list.* *See Master Policy for benefit limits*	20% after deductible Summit Network: Alpine Home Medical
Hearing Aids *Requires preauthorization*	20% after deductible
Medical Supplies *See Master Policy for benefit limits*	20% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	20% after deductible
Injections *Includes allergy injections. See above for allergy serum.* *Requires preauthorization if over $750*	**Under $50:** No charge **Over $50:** 20% after deductible
Infertility Services* *Up to $1,500 per plan year. Up to $5,000 Lifetime Maximum.* *Select services only. See Master Policy for details*	50% after deductible
Orthotics *Up to two pair per plan year*	20% after deductible
Preventive Eye Exam *Limited to one per plan year*	No charge
Temporomandibular Joint Dysfunction* *Non-surgical. Up to $2,000 lifetime maximum. See Master Policy for details*	50% after deductible

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

PEHP Health & Benefits

High Deductible Plus

Summit & 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.

Percentages indicate your share of PEHP's In-Network Rate.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $2,000 Double/family plans: $4,000 *One person or a combination can meet the $4,000 double/family deductible*	
Plan year Out-of-Pocket Maximum	Single plans: $5,000 Double/family plans: $10,000 *One person may not apply more than $5,000 toward the double/family maximum*	
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge	40% after deductible
PROFESSIONAL SERVICES		
PEHP e-Care	**Medical:** $10 co-pay per visit after deductible	Not applicable
PEHP Value Clinics	**Medical:** 20% after deductible	Not applicable
Primary Care Visits | *Includes office surgeries and inpatient visits*	$20 co-pay after deductible	40% after deductible
Specialist Visits | *Includes office surgeries and inpatient visits*	$35 co-pay after deductible	40% after deductible
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	$35 co-pay after deductible	$35 co-pay after deductible
Diagnostic Tests, Labs, X-rays	20% after deductible	40% after deductible
Mental Health and Substance Abuse *Treatment for Autism requires preauthorization*	**Outpatient:** $30 co-pay per visit after deductible for psychiatrist; $20 co-pay per visit after deductible for psychologist/LCSW/APRN. **Inpatient:** 20% after deductible	40% after deductible
PRESCRIPTION DRUGS | ***All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	**Tier 1:** $5 co-pay **Tier 2:** 20% of discounted cost, $25 minimum / $75 maximum **Tier 3:** 35% 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
90-day Pharmacy *Maintenance only*	**Tier 1:** $10 co-pay **Tier 2:** 20% of discounted cost, $50 minimum / $150 maximum **Tier 3:** 35% of discounted cost, $100 minimum / $200 maximum	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. You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for Out-of-Network Providers.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
PRESCRIPTION DRUGS | *All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org*		
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	**Tier A:** 40%. No maximum co-pay **Tier B:** 50%. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C1:** 10%. No maximum co-pay **Tier C2:** 20%. No maximum co-pay **Tier C3:** 30%. No maximum co-pay	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	$50 co-pay after deductible per visit	40% after deductible
Urgent Care Facility	$35 co-pay after deductible	40% after deductible
Emergency Room *Medical emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	20% after deductible	20% after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible	
Diagnostic Tests, X-rays, Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge after deductible	40% after deductible
Diagnostic Tests, X-rays, Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	20% after deductible	40% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible	40% after deductible
Physical, Speech, and Occupational Therapy *Outpatient – requires preauthorization after 20 visits per plan year for each therapy type*	$20 co-pay per visit after deductible	40% after deductible
Mental Health & Substance Abuse	$50 co-pay after deductible per visit	40% after deductible
INPATIENT FACILITY SERVICES		
Medical & Surgical *All out-of-network facilities and some in-network facilities require preathorization.* *See Master Policy for details*	20% after deductible	40% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible	40% after deductible
Hospice	20% after deductible	40% after deductible
Rehabilitation *Up to 45 days per plan year. Requires preauthorization*	20% after deductible	40% after deductible
Mental Health & Substance Abuse *All services require Preauthorization.*	20% per visit after deductible	40% after deductible

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption | *See limitations*	No charge after deductible, plan pays up to $2,500 per adoption	
Allergy Serum	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Chiropractic Care | *Requires preauthorization after 20 visits, up to 40 visits per plan year*	$20 co-pay per visit after deductible	Not covered
Durable Medical Equipment *Some DME requires preauthorization. Visit www.pehp.org for complete list.* *See Master Policy for benefit limits*	20% after deductible	40% after deductible
Hearing Aids *Requires preauthorization*	20% after deductible	40% after deductible
Medical Supplies *See the Master Policy for benefit limits*	20% after deductible	40% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires preauthorization*	20% after deductible	40% after deductible
Infertility Services *Up to $1,500 per plan year. Up to $5,000 Lifetime Maximum. Select services only. See Master Policy for details*	50% after deductible	Not covered
Injections *Includes allergy injections. See above for allergy serum. Requires preauthorization if over $750*	20% after deductible	40% after deductible
Orthotics *Up to two pair per plan year*	20% after deductible	40% after deductible
Preventive Eye Exam *Limited to one per plan year*	No charge	Not covered
Temporomandibular Joint Dysfunction *Non-surgical. Up to $2,000 lifetime maximum.* *See Master Policy for details*	50% after deductible	50% after deductible

PEHP Health & Benefits

High Deductible

Summit & 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.

Percentages indicate your share of PEHP's In-Network Rate.

	In-Network Provider
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS	
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $2,000 Double/family plans: $4,000 *One person or a combination can meet the $4,000 double/family deductible*
Plan year Out-of-Pocket Maximum	Single plans: $5,000 Double/family plans: $10,000 *One person may not apply more than $5,000 toward the double/family maximum*
ANNUAL PREVENTIVE CARE	
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge
PROFESSIONAL SERVICES	
PEHP e-Care	**Medical:** $10 co-pay per visit after deductible
PEHP Value Clinics	**Medical:** 20% after deductible
Primary Care Visits | *Includes office surgeries and inpatient visits*	$20 co-pay after deductible
Specialist Visits | *Includes office surgeries and inpatient visits*	$35 co-pay after deductible
Surgery and Anesthesia	20% after deductible
Emergency Room Specialist Visits	$35 co-pay after deductible
Diagnostic Tests, Labs, X-rays	20% after deductible
Mental Health and Substance Abuse *Treatment for Autism requires preauthorizatione*	**Outpatient:** $30 co-pay per visit after deductible for psychiatrist; $20 co-pay per visit after deductible for psychologist/LCSW/APRN. **Inpatient:** 20% after deductible
PRESCRIPTION DRUGS | ***All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org***	
30-day Pharmacy *Retail only*	**Tier 1:** $5 co-pay **Tier 2:** 20% of discounted cost, $25 minimum / $75 maximum **Tier 3:** 35% of discounted cost, $50 minimum / $100 maximum
90-day Pharmacy *Maintenance only*	**Tier 1:** $10 co-pay **Tier 2:** 20% of discounted cost, $50 minimum / $150 maximum **Tier 3:** 35% of discounted cost, $100 minimum / $200 maximum

	In-Network Provider
PRESCRIPTION DRUGS | ***All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org***	
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C1:** 10%. No maximum co-pay **Tier C2:** 20%. No maximum co-pay **Tier C3:** 30%. No maximum co-pay
OUTPATIENT FACILITY SERVICES	
Outpatient Facility and Ambulatory Surgical Center	$50 co-pay after deductible per visit
Urgent Care Facility	$35 co-pay after deductible
Emergency Room *Medical emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	20% after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible
Diagnostic Tests, X-rays, Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge after deductible
Diagnostic Tests, X-rays, Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	20% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible
Physical, Speech, and Occupational Therapy *Outpatient – requires preauthorization after 20 visits per plan year for each therapy type*	$20 co-pay per visit after deductible
Mental Health & Substance Abuse	$50 co-pay after deductible per visit
INPATIENT FACILITY SERVICES	
Medical & Surgical *All out-of-network facilities and some in-network facilities require preathorization.* *See Master Policy for details*	20% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible
Hospice	20% after deductible
Rehabilitation *Up to 45 days per plan year. Requires preauthorization*	20% after deductible
Mental Health & Substance Abuse *All services require Preauthorization.*	20% per visit after deductible

	In-Network Provider
MISCELLANEOUS SERVICES	
Adoption | *See limitations*	No charge after deductible, plan pays up to $2,500 per adoption
Allergy Serum	20% of In-Network Rate after deductible
Chiropractic Care | *Requires preauthorization after 20 visits, up to 40 visits per plan year*	$20 co-pay per visit after deductible
Durable Medical Equipment *Some DME requires preauthorization. Visit www.pehp.org for complete list.* *See Master Policy for benefit limits*	20% after deductible
Hearing Aids *Requires preauthorization*	20% after deductible
Medical Supplies *See the Master Policy for benefit limits*	20% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires preauthorization*	20% after deductible
Infertility Services *Up to $1,500 per plan year. Up to $5,000 Lifetime Maximum. Select services only. See Master Policy for details*	50% after deductible
Injections *Includes allergy injections. See above for allergy serum. Requires preauthorization if over $750*	20% after deductible
Orthotics *Up to two pair per plan year*	20% after deductible
Preventive Eye Exam *Limited to one per plan year*	No charge
Temporomandibular Joint Dysfunction *Non-surgical. Up to $2,000 lifetime maximum.* *See Master Policy for details*	50% after deductible