PeakHealth

Individual Health Insurance

Exclusive Provider Organization (EPO)
Medical and Outpatient Prescription Drug Plan

Peak Gold 2500
Statement of Benefits

Highlights

Annual Deductible*	Individual: $2,500 Family: $5,000
Coinsurance	25%
Annual Out-of-Pocket Maximum**	Individual: $8,600 Family: $17,200

* Deductible: The individual Deductible applies to each covered family member. No one person can contribute more than the individual Deductible amount. Once two or more covered family members' Deductibles combine to equal the family Deductible amount, the Deductible will be satisfied for the family for that Calendar Year.

** Out-of-Pocket Maximum: The individual Out-of-Pocket Limit applies to each covered family member. Once two or more covered family members' Out-of-Pocket Limits combine to equal the family Out-of-Pocket Limit amount, the Out-of-Pocket Limit will be satisfied for the family for that Calendar Year.

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Preventive Services As defined by federal & state law	No charge	Refer to your Certificate of Coverage
Office Visits[2]		
Primary Includes Primary Care Provider and Mental Health/Substance Abuse	$30 copay	None
Specialist	$60 copay	None
Urgent Care[1]	$45 copay	None
Diagnostic Services[1]		
Lab	25% coinsurance after deductible	None
X-Ray/Radiology	25% coinsurance after deductible	None
Advanced Imaging	25% coinsurance after deductible	None

Mammograms (Outpatient) Preventive	No Charge	Refer to your Certificate of Coverage
Diagnostic[1]	25% coinsurance after deductible	None
Inpatient Services Facility Fee	25% coinsurance after deductible	None
Physician/Surgeon Fees	25% coinsurance after deductible	None
Skilled Nursing Facility	25% coinsurance after deductible	None
Outpatient Services Facility Fee	25% coinsurance after deductible	None
Physician/Surgeon Fees	25% coinsurance after deductible	None
Maternity Services[1] Inpatient Services	25% coinsurance after deductible	None
Outpatient Services	25% coinsurance after deductible	None
		None
Ambulance Services	25% coinsurance after deductible	None
Emergency Health Care Services[1]	25% coinsurance after deductible	If admitted to the hospital directly from the Emergency Department, these services will be covered the same as inpatient services and the applicable copayment and coinsurance will apply.
Habilitative Services Physical/Occupational Therapy	$30 copay	30 visits each per Benefit Year If received from a Chiropractor, see Chiropractic Care Services for cost share.
Speech Therapy	$30 copay	None
Manipulation Therapy	$30 copay	30 visits per Benefit Year
Rehabilitative Services Physical/Occupational Therapy	$30 copay	30 visits each per Benefit Year If received from a Chiropractor, see Chiropractic Care Services for cost share.
Speech Therapy	$30 copay	None
Pulmonary Rehabilitation	$30 copay	30 visits per Benefit Year
Cardiac Rehabilitation Services	$30 copay	36 visits per Benefit Year
Manipulation Therapy	$30 copay	30 visits per Benefit Year If received from a Chiropractor, see Chiropractor Care Services for cost share.
Other Rehabilitative Services Includes Chemotherapy, Dialysis, and Radiation	25% coinsurance after deductible	Refer to your Certificate of Coverage

Chiropractor Care Services		
Rehabilitative Services		
Physical Therapy	$30 copay	Limits for Physical Therapy and Manipulation apply
Manipulation Therapy	$30 copay	Limits for Physical Therapy and Manipulation apply
Habilitation Services		
Physical Therapy	$30 copay	Limits for Physical Therapy and Manipulation apply
Manipulation Therapy	$30 copay	Limits for Physical Therapy and Manipulation apply
Chronic Pain Treatment		
Physical/Occupational Therapy	$30 copay	
Chronic Pain Management Program	$30 copay	20 combined visits per event, in addition to any Rehabilitative and Habilitative visits
Chiropractic/Osteopathic Manipulation Services	$30 copay	
Autism Spectrum Disorder Services		
Physical/Occupational Therapy	$30 copay	Combined limit with Habilitative Services
Speech Therapy	$30 copay	Combined limit with Habilitative Services
Adaptive Behavior Treatment	$30 copay	Includes Applied Behavior Analysis (ABA)
Behavioral Health Services		
Office Visits[2]	$30 copay	None
Outpatient Services[1]		
Intensive Outpatient Program (IOP) Services	25% coinsurance after deductible	None
Partial Hospitalization Program (PHP) Services	25% coinsurance after deductible	None
Residential Services	25% coinsurance after deductible	None
Opioid Treatment Program	25% coinsurance after deductible	None
Inpatient Services[1]	25% coinsurance after deductible	None
Transplant Services	25% coinsurance after deductible	Refer to your Certificate of Coverage
Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	Covered the same as office visits, inpatient services, and outpatient services	None
Home Health		
Private Duty Nursing	25% coinsurance after deductible	35 visits per Benefit Year. A visit equals 8 hours.
Home Infusion Therapy	25% coinsurance after deductible	Included in all other service limits
All Other Services	25% coinsurance after deductible	100 combined visits per Benefit Year. A visit equals at least 4 hours.

Hospice Care	25% coinsurance after deductible	Refer to your Certificate of Coverage
Medical Supplies, Durable Medical Equipment, and Appliances		
Appliances	25% coinsurance after deductible	Refer to your Certificate of Coverage
Durable Medical Equipment	25% coinsurance after deductible	Refer to your Certificate of Coverage
Medical Supplies	25% coinsurance after deductible	Refer to your Certificate of Coverage
Orthotic Device	25% coinsurance after deductible	Refer to your Certificate of Coverage
Prosthetics	25% coinsurance after deductible	Refer to your Certificate of Coverage
Prescription Drugs		
Preventive Drugs	No charge	Up to a 30-day supply for Specialty Drugs
Generic Drugs	$15 copay	Up to a 90-day supply for all other Retail and Mail Order.
Preferred Brand Drugs	$30 copay	
Non-Preferred Brand Drugs	$60 copay	Any copays shown are for a 30-day supply. 90-day supplies available at 3 times the copay.
Specialty Drugs	$250 copay	Insulin cost share not to exceed $35 and diabetic devices not to exceed $100 per 30-day supply in aggregate.
Vision (pediatric)		
Children's Eye Exam	No Charge	1 routine eye exam per Benefit Year
Low Vision Testing and Aids	No Charge	Limited to one evaluation and aid per Benefit Year.
Children's Eyewear	No Charge	Limited to one pair of glasses or contact lenses per Benefit Year. If medically necessary, a replacement pair of glasses is allowed. Refer to your Certificate of Coverage for additional eyewear options that may have an additional charge.
Dental (pediatric)		
Dental Check-Up	No Charge	2 Visits per Benefit Year
Basic Dental Work	No Charge	None
Major Dental Work	50% Coinsurance	None
Orthodontia	50% Coinsurance	None
Other Dental Services		
Accidental Dental	25% coinsurance after deductible	Refer to your Certificate of Coverage

Other Covered Services[3]		
Allergy Testing	25% coinsurance after deductible	None
Allergy Injections	25% coinsurance after deductible	None
Allergy Serum	25% coinsurance after deductible	None

[1] When receiving covered services at an office, urgent care or hospital visit, member may be subject to cost share charges from both the facility and the physician/surgeon.

[2] Charge shown for the office visit. Additional services rendered during the office visit may be subject to their applicable additional copayment or deductible/coinsurance as specified in the Statement of Benefits. Charges applied per provider, per date of service.

[3] Member cost-sharing may vary based on the place of service where it is rendered. Additional services and evaluations rendered during the visit may be subject to their applicable additional copayment or deductible/coinsurance as specified in the Statement of Benefits.

Precertification: Some services and items require precertification. This is the process used by the Plan to determine if it meets medical necessity and coverage requirements prior to the service being provided. The provider, or the member when using an out-of-network provider, is responsible for obtaining prior authorization for the services and items described on the precertification list. Please refer to the precertification list attached to your Certificate of Coverage for additional detail or you can obtain the list at peakhealth.org.

This Statement of Benefits is a summary of your financial responsibility when you receive health care services from a physician, pharmacy, facility, or other provider. All Covered Services are subject to the conditions, exclusions, limitations, terms, and rules of the Certificate of Coverage including any rider/enhancements or amendments. Except as otherwise provided in the Evidence of Coverage, Covered Services must be provided to you by a network provider and medically necessary. The Plan does not cover all healthcare service expenses. In the event of any discrepancy between this Statement of Benefits and your Certificate of Coverage, the Certificate of Coverage shall control. For more detailed information about your Covered Services, please refer to the Certificate of Coverage at peakhealth.org

For Covered Services listed in the Certificate of Coverage that are not specifically listed on this Statement of Benefits, the cost sharing is equal to the coinsurance after the deductible.

The copays and coinsurance listed in the 'You Pay' column would only apply if the item or service is not furnished directly by a provider meeting the criteria outlined below, otherwise there would be no cost to you.

1) an Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603);
2) a provider who was referred by one of the organizations listed in item 1.

You may view the Access Plan required by Health Benefit Plan Network Access and Adequacy Act online at www.peakhealth.org. You may also contact us at 1-833-569-7325 to request a copy.