PeakHealth

# Individual Health Insurance

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

## Peak Gold 2500 Off-Exchange
## Statement of Benefits

**Highlights**

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| Annual Deductible* | Individual: $2,500<br>Family: $5,000 |
| Coinsurance | 25% |
| Annual Out-of-Pocket Maximum** | Individual: $8,600<br>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**<br>As defined by federal & state law | No charge | Refer to your Certificate of Coverage |
| **Office Visits**[2]<br>Primary<br>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]<br>Lab | 25% coinsurance after deductible | None |
| X-Ray/Radiology | 25% coinsurance after deductible | None |
| Advanced Imaging | 25% coinsurance after deductible | None |

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| **Mammograms** (Outpatient)<br>Preventive | No Charge | Refer to your Certificate of Coverage |
| Diagnostic[1] | 25% coinsurance after deductible | None |
| **Inpatient Services**<br>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**<br>Facility Fee | 25% coinsurance after deductible | None |
| Physician/Surgeon Fees | 25% coinsurance after deductible | None |
| **Maternity Services**[1]<br>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**<br>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**<br>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<br>If received from a Chiropractor, see Chiropractor Care Services for cost share. |
| Other Rehabilitative Services<br>Includes Chemotherapy, Dialysis, and Radiation | 25% coinsurance after deductible | Refer to your Certificate of Coverage |

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| **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. |

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| **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] | | |
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| 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.