PeakHealth

Individual Health Insurance

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

Peak Silver 6400
Statement of Benefits

Highlights

Annual Deductible*	Individual: $6,400 Family: $12,800
Coinsurance	40%
Annual Out-of-Pocket Maximum**	Individual: $10,300 Family: $20,600

* 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	$40 copay	None
Specialist	$80 copay	None
Urgent Care[1]	$60 copay	None
Diagnostic Services[1] Lab	40% coinsurance after deductible	None
X-Ray/Radiology	40% coinsurance after deductible	None

Advanced Imaging	40% coinsurance after deductible	None
Mammograms (Outpatient) Preventive Diagnostic[1]	 No Charge 40% coinsurance after deductible	 Refer to your Certificate of Coverage None
Inpatient Services Facility Fee Physician/Surgeon Fees Skilled Nursing Facility	 40% coinsurance after deductible 40% coinsurance after deductible 40% coinsurance after deductible	 None None None
Outpatient Services Facility Fee Physician/Surgeon Fees	 40% coinsurance after deductible 40% coinsurance after deductible	 None None
Maternity Services[1] Inpatient Services Outpatient Services	 40% coinsurance after deductible 40% coinsurance after deductible	 None None None
Ambulance Services	40% coinsurance after deductible	None
Emergency Health Care Services[1]	40% 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 Speech Therapy Manipulation Therapy	 $40 copay $40 copay $40 copay	 30 visits each per Benefit Year If received from a Chiropractor, see Chiropractic Care Services for cost share. None 30 visits per Benefit Year
Rehabilitative Services Physical/Occupational Therapy Speech Therapy Pulmonary Rehabilitation Cardiac Rehabilitation Services Manipulation Therapy	 $40 copay $40 copay $40 copay $40 copay $40 copay	 30 visits each per Benefit Year If received from a Chiropractor, see Chiropractic Care Services for cost share. None 30 visits per Benefit Year 36 visits per Benefit Year 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	40% coinsurance after deductible	Refer to your Certificate of Coverage
Chiropractor Care Services		
Rehabilitative Services		
Physical Therapy	$40 copay	Limits for Physical Therapy and Manipulation apply
Manipulation Therapy	$40 copay	Limits for Physical Therapy and Manipulation apply
Habilitation Services		
Physical Therapy	$40 copay	Limits for Physical Therapy and Manipulation apply
Manipulation Therapy	$40 copay	Limits for Physical Therapy and Manipulation apply
Chronic Pain Treatment		
Physical/Occupational Therapy	$40 copay	
Chronic Pain Management Program	$40 copay	20 combined visits per event, in addition to any Rehabilitative and Habilitative visits
Chiropractic/Osteopathic Manipulation Services	$40 copay	
Autism Spectrum Disorder Services		
Physical/Occupational Therapy	$40 copay	Combined limit with Habilitative Services
Speech Therapy	$40 copay	Combined limit with Habilitative Services
Adaptive Behavior Treatment	$40 copay	Includes Applied Behavior Analysis (ABA)
Behavioral Health Services		
Office Visits[2]	$40 copay	None
Outpatient Services[1]		
Intensive Outpatient Program (IOP) Services	40% coinsurance after deductible	None
Partial Hospitalization Program (PHP) Services	40% coinsurance after deductible	None
Residential Services	40% coinsurance after deductible	None
Opioid Treatment Program	40% coinsurance after deductible	None
Inpatient Services[1]	40% coinsurance after deductible	None
Transplant Services	40% 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	40% coinsurance after deductible	35 visits per Benefit Year. A visit equals 8 hours.
Home Infusion Therapy	40% coinsurance after deductible	Included in all other service limits
All Other Services	40% coinsurance after deductible	100 combined visits per Benefit Year. A visit equals at least 4 hours.
Hospice Care	40% coinsurance after deductible	Refer to your Certificate of Coverage
Medical Supplies, Durable Medical Equipment, and Appliances		
Appliances	40% coinsurance after deductible	Refer to your Certificate of Coverage
Durable Medical Equipment	40% coinsurance after deductible	Refer to your Certificate of Coverage
Medical Supplies	40% coinsurance after deductible	Refer to your Certificate of Coverage
Orthotic Device	40% coinsurance after deductible	Refer to your Certificate of Coverage
Prosthetics	40% 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	$20 copay	Up to a 90-day supply for all other Retail and Mail Order.
Preferred Brand Drugs	$40 copay	
Non-Preferred Brand Drugs	$80 copay after deductible	Any copays shown are for a 30-day supply. 90-day supplies available at 3 times the copay.
Specialty Drugs	$350 copay after deductible	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	40% coinsurance after deductible	Refer to your Certificate of Coverage
Other Covered Services[3] Allergy Testing	40% coinsurance after deductible	None
Allergy Injections	40% coinsurance after deductible	None
Allergy Serum	40% 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.