### DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS

| Plan year Deductible | Single plans: $350  
|                     | Double/family plans: $350 per person, $700 per family  
|                     | Does not apply to Out-of-Pocket Maximum  
| Plan year Out-of-Pocket Maximum | Single plans: $3,000  
|                               | Double plans: $3,000 per person, $6,000 per double  
|                               | Family plans: $3,000 per person, $9,000 per family  
|                               | Please refer to the Master Policy for exceptions to the out-of-pocket maximum.  

### ANNUAL PREVENTIVE CARE

| Preventive services allowed by Affordable Care Act | No charge  
| Annual physical exam, immunizations.  
| See full list at www.pehp.org/preventiveservices | 40% after deductible  

### PEHP VALUE PROVIDERS

| PEHP Value Providers | Starting at $10 co-pay per visit  
| Cash Back opportunities available. Visit www.pehp.org/valueproviders | Not applicable  

### PROFESSIONAL SERVICES

| Primary Care Visits | $25 co-pay per visit  
| Includes office surgeries, inpatient visits and Autism services | IHC: $35 co-pay per visit for Summit network  
| | University of Utah Medical Group: $35 co-pay per visit  
| | 40% after deductible  
| Specialist Visits | $35 co-pay per visit  
| Includes office surgeries, inpatient visits and Autism services | IHC: $45 co-pay per visit for Summit network  
| | University of Utah Medical Group: $45 co-pay per visit  
| | 40% after deductible  
| Surgery and Anesthesia | 20% after deductible  
| Emergency Room Specialist Visits | $35 co-pay per visit  
| Diagnostic Tests, Labs, X-rays | $35 co-pay per visit  
| 20% after deductible | 40% after deductible  

### PRESCRIPTION DRUGS

| 30-day Pharmacy | Tier 1: $10 co-pay  
| Retail only | Tier 2: 25% of discounted cost.  
| | $25 minimum, no maximum co-pay  
| | Tier 3: 50% of discounted cost.  
| | $50 minimum, no maximum co-pay  
| 90-day Pharmacy | Tier 1: $20 co-pay  
| Maintenance only | Tier 2: 25% of discounted cost.  
| | $50 minimum, no maximum co-pay  
| | Tier 3: 50% of discounted cost.  
| | $100 minimum, no maximum co-pay  

Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance.

### 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- 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.*

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*Weber State 2024-25 | Medical Benefits Grid | Traditional*
### Outpatient Facility Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider*</th>
</tr>
</thead>
</table>
| Specialty Medications, retail pharmacy                | 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              | 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 Accredro| 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 and Ambulatory Surgical Center     | 20% after deductible  
40% after deductible | 20% after deductible  
40% after deductible |
| Urgent Care Facility                                  | $45 co-pay per visit  
40% after deductible | 20% of In-Network Rate, minimum $150 co-pay per visit  
20% of In-Network Rate, minimum $150 co-pay per visit |
| Emergency Room                                         | 20% of In-Network Rate, minimum $150 co-pay per visit  
20% after deductible  
40% after deductible |
| Ambulance (ground or air)                             | 20% after deductible | 20% after deductible |
| Diagnostic Tests, Labs, X-rays – Minor                | 20% after deductible  
40% after deductible | 20% after deductible  
40% after deductible |
| Chemotherapy, Radiation, and Dialysis                  | 20% after deductible  
40% after deductible | 20% after deductible  
40% after deductible |
| Physical and Occupational Therapy                      | Applicable co-pay per visit  
40% after deductible | 40% after deductible |
| Mental Health & Substance Abuse                        | 20% after deductible  
40% after deductible | 20% after deductible  
40% after deductible |

### Inpatient Facility Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider*</th>
</tr>
</thead>
</table>
| Hospital Services Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation | 20% after deductible  
40% after deductible | 20% after deductible  
40% after deductible |
| Skilled Nursing Facility and Residential Treatment                     | 20% after deductible  
40% after deductible | 20% after deductible  
40% after deductible |
# MISCELLANEOUS SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption / Assisted Reproductive Technology (ART)</td>
<td>20% after deductible, up to $4,000 per adoption or up to $4,000 per single-embryo ART implant</td>
<td>Balance billing may apply</td>
</tr>
<tr>
<td>ART requires Preauthorization. Excludes multiple-embryo ART implants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Serum</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Chiropractic care</td>
<td>Up to 10 visits per plan year</td>
<td>Applicable office co-pay per visit</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>See Master Policy for benefit limits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health/Skilled Nursing</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Up to 60 visits per plan year. Requires Preauthorization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Hospice</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Injections</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Includes allergy injections. See above for allergy serum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infertility Services</td>
<td>Select services only. See Master Policy for details.</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Temporomandibular Joint Dysfunction</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Non-surgical. Up to $1,000 lifetime maximum. See Master Policy for details</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>