Base Plan: Summit & Advantage Networks Available

You always pay the deductible and copayment ($). The coinsurance (%) shows what **the plan pays** after the deductible, unless noted otherwise.

	Preferred and Participating In-Network
Annual Deductible (Per plan year)	$2,750 Individual / $8,250 Family
	If any family member reaches the Individual deductible, then the deductible is satisfied for that family member. If any combination of family members reach the Family deductible, then the deductible is satisfied for the entire family.
Annual Out-of-Pocket Maximum (Per plan year)	$7,000 Individual / $14,000 Family
	If any family member reaches the Individual out of pocket maximum, then the out-of-pocket maximum is satisfied for that family member. If any combination of family members reach the Family out of pocket maximum, then the out-of-pocket maximum is satisfied for the entire family.
Office Visit Primary Care Preventive ** Specialists or Secondary Chiropractic Intermountain Connect Care	 $45 Copay Covered 100% Deductible Waived $60 Copay $60 Copay (20 visits PPY) $10 Copay
Lab and X-ray Minor Labs & Imaging - Independent Minor Labs & Imaging - Hospital Major Labs & Imaging - Independent Major Labs & Imaging- Hospital	 Covered 90% Covered 70% After Deductible Covered 90% After Deductible Covered 70% After Deductible
Urgent Care	$70 Copay
Emergency Room	Covered 80% After Deductible
Hospitalization Inpatient	 Covered 70% After Deductible
Outpatient Surgery	Covered 90% After Deductible
In-Network Prescriptions	
Deductible	$250 (waived for Generic)
Pharmacy (Generic Required)	$25 / 35% / 50% / 50%
Maintenance or Mail Order	$50 / 35% / 50% / 50%

***** Member will be responsible for amounts billed by non-participating providers in excess of eligible medical expense amount.

****** Please refer to your provided PEHP materials for a full list of covered preventive services and limitations.

PPY-Per Plan Year