USBA Gold

Coverage Period: 9/1/15-8/31/16

Summary of Benefits and Coverage: What this Plan Covers & What it Costs | **Coverage for:** Individual and Family plans | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.pehp.org or by calling 1-800-765-7347.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** per person/**$0** per family for contracted providers. **$500** per person/**$1,000** per family for non-contracted providers. Doesn't apply to contracted provider visits or preventive care received from contracted providers.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, September 1st). See the chart starting on Page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on Page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. Medical: **$3,500** per person/**$7,000** per family for contracted providers. **$7,500** per person/**$15,000** per family for non-contracted providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and healthcare this plan doesn't cover. See benefits summary.	Even though you pay these expenses, they don't count toward the **out-of-pocket** limit.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. For a list of contracted providers, go to www.pehp.org or call 1-800-765-7347.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, **preferred**, or participating for providers in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

08/17/2015
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PEHP

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **Contracted Providers** by charging you lower **deductibles**, **co-payments** and **coinsurance** amounts.

Medical Event	Services You May Need	Your Cost If You Use a Contracted Provider	Your Cost If You Use a Non-Contracted Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay/visit	40% of allowed amount (AA) after deductible	The following services are not covered: office visits for repetitive injections when the only service provided is the injection; charges for after hours or holiday; testing and treatment for developmental delay. Infertility charges are payable at 50% of allowed amount after deductible, up to $1,500 per plan year, $5,000 per lifetime.
	Specialist visit	$40 co-pay/visit	40% of AA after deductible	
	Other practitioner office visit	n/a	n/a	
	Preventive care/ screening/immunization	No charge	Full charge	Limited to the Affordable Care Act list of preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	10% of AA	40% of AA after deductible	Attended sleep studies, and any sleep studies done in a facility require pre-authorization and are limited to $2,000 in a 3-year period. Infertility services are payable at 50% of AA after deductible for eligible services, and have a maximum of $1500 per plan year and $5000 per lifetime. Genetic testing requires pre-authorization. Some scans require pre-authorization.
	Imaging (CT/PET scans, MRIs)	10% of AA	40% of AA after deductible	

Medical Event	Services You May Need	Your Cost If You Use a Contracted Provider	Your Cost If You Use a Non-Contracted Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.pehp.org.**	Generic drugs	$15 co-pay/retail	The preferred co-pay plus the difference above the discounted cost	PEHP formulary must be used. Retail and mail-order prescriptions not refillable until 75% of the total prescription supply within the last 180 days is used; some drugs require step therapy and/or pre-authorization. Enteral formula requires pre-authorization. No coverage for: non-FDA approved drugs; vitamins, minerals, food supplements, homeopathic medicines, and nutritional supplements; compounding fees, powders, and non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication.
	Preferred brand drugs	25% of discounted cost $30 minimum/$90 maximum	The preferred co-pay plus the difference above the discounted cost	
	Non-preferred brand drugs	50% of discounted cost $55 minimum/ $200 maximum	The preferred co-pay plus the difference above the discounted cost	
	Specialty drugs	Medical - 20% of AA after deductible for Tier A drugs, 30% of AA after deductible for Tier B drugs	The preferred co-pay plus the difference above the discounted cost	PEHP uses the specialty pharmacy Accredo and Home Health Providers for specialty drugs, pre-authorization may be required. Using Accredo may reduce your cost.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% of AA after $250 co-pay	40% of AA after deductible and $250 co-pay	No coverage for: cosmetic surgery; bariatric surgery. Payable at 50% of AA after deductible when medically necessary: breast reduction; blepharoplasty; eligible infertility surgery; sclerotherapy of varicose veins; microphlebectomy; spinal cord stimulators (requires pre-authorization).
	Physician/surgeon fees	10% of AA	40% of AA after deductible	
If you need immediate medical attention	Emergency room services	10% of AA after $150 co-pay	10% of AA after $150 co-pay plus any balance billing	None
	Emergency medical transportation	10% of AA	10% of AA after deductible	Ambulance charges for the convenience of the patient or family are not covered. Air ambulance covered only in life-threatening emergencies and only to the nearest facility where proper medical care is available.
	Urgent care	$30 co-pay	40% of AA after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% of AA after $500 co-pay	40% of AA after deductible and $500 co-pay	No coverage for: custodial care and/or maintenance therapy; take-home medications. Payable at 50% of AA after deductible when medically necessary: breast reduction; blepharoplasty; eligible infertility surgery; sclerotherapy of varicose veins; microphlebectomy; spinal cord stimulators (requires pre-authorization). Inpatient mental health/substance abuse, skilled nursing facilities, inpatient rehab facilities, out-of-network inpatient, out-of-state inpatient and some in-network facilities require pre-authorization
	Physician/surgeon fee	10% of AA	40% of AA after deductible	

Medical Event	Services You May Need	Your Cost If You Use a Contracted Provider	Your Cost If You Use a Non-Contracted Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% of AA	40% of AA after deductible	No coverage for: milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, situational disturbances, residential treatment programs. Some of these services may be covered through your employer's Employee Assistance Program or Life Assistance Counseling. Outpatient mental health, behavioral health, or substance abuse is limited to 20 visits per plan year.
	Mental/Behavioral health inpatient services	20% of AA	40% of AA after deductible	
	Substance use disorder outpatient services	20% of AA	40% of AA after deductible	
	Substance use disorder inpatient services	20% of AA	40% of AA after deductible	
If you are pregnant	Prenatal and postnatal care	10% of AA	40% of AA after deductible	Mother and baby's charges are separate.
	Delivery and all inpatient services	10% of AA after $500 co-pay	40% of AA after deductible and $500 co-pay	
If you need help recovering or have other special health needs	Home health care	10% of AA	40% of AA after deductible	60 visits per plan year. Requires pre-authorization. No coverage for custodial care.
	Rehabilitation services	10% of AA after$500 co-pay/visit (inpatient) or $40 co-pay/visit (outpatient)	40% of AA after deductible and $500 co-pay/visit (inpatient) or 40% of AA after deductible (outpatient)	Outpatient Physical Therapy (PT)/Occupational Therapy (OT) is subject to a 20 visit maximum per plan year, no pre-authorization required. Speech Therapy (ST) requires pre-authorization after the initial evaluation, maximum limit of 60 days per lifetime. Maintenance therapy and therapy for developmental delay are not covered.
	Habilitation services	10% of AA after$500 co-pay/visit (inpatient) or $40 co-pay/visit (outpatient)	40% of AA after deductible and $500 co-pay/visit (inpatient) or 40% of AA after deductible (outpatient)	
	Skilled nursing care	10% of AA	40% of AA after deductible	Requires pre-authorization. No coverage for custodial care. Maximum of 60 visits per plan year.
	Durable medical equipment	20% of AA after deductible	40% of AA after deductible	Sleep disorder equipment/supplies are limited to $2,500 in a 5-year period. Equipment over $750, rentals over 60 days, or as indicated in Appendix A of your Master Policy require pre-authorization. No coverage for used equipment or unlicensed providers of equipment.
	Hospice service	10% of AA	40% of AA after deductible	Requires pre-authorization. 6 months in a 3-year period maximum.

Medical Event	Services You May Need	Your Cost If You Use a Contracted Provider	Your Cost If You Use a Non-Contracted Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Over age 5 and adults: $40 co-pay per visit.	Full charge	One routine exam per plan year ages 3-5 as allowed under the Affordable Care Act.
	Glasses	Full charge	Full charge	Not covered under this plan.
	Dental check-up	Full charge	Full charge	Not covered under this plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture (covered on Preferred network plans only)
- Ambulance... charges for the convenience of the patient or family; air ambulance for non-life-threatening situations
- Bariatric surgery
- Charges for which a third party, auto insurance, or worker's compensation plan are responsible
- Complications from any non-covered services devices, or drugs
- Cosmetic surgery
- Custodial care and/or maintenance therapy
- Dental care (Adults or children), unless related to an accident
- Developmental delay — testing and treatment
- Equipment, used or from unlicensed providers
- Foot care — routine
- Glasses
- Mental Health — milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, situational disturbances, residential treatment programs
- Non-emergency care when traveling outside the U.S.
- Nursing — private duty
- Nutritional supplements, including — vitamins, minerals, food supplements, homeopathic medicines
- Office visits — for repetitive injections when the only service provided is the injection; charges for after hours or holiday
- Prescription drugs not on the PEHP formulary; compounding fees, powders, and non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication; take-home medications
- Robot use during surgery
- Weight-loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
• Chiropractic care	• Long-term care
• Coverage provided outside the U.S.	• Routine eye care (Adults and children, exams only)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-765-7347.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: www.pehp.org or 1-800-765-7347.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy does provide minimum essential coverage. **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-765-7347.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-765-7347.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-765-7347.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-765-7347.]

––––––––––––––––––––––To see examples of how this plan might cover costs for a sample medical situation, see the next page.––––––––––––––––––––––

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a Baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,786
- **Patient pays** $754

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$754
Limits or exclusions	$0
Total	**$754**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,860
- **Patient pays** $540

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$540
Limits or exclusions	$0
Total	**$540**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.