
 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.HealthComp.com or call 1-855-727-5267. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-877-552-7247 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1: \$125 person/\$375 family Tier 2: \$275 person/\$825 family Tier 3: \$600 person/\$1,800 family Doesn't apply to preventive care by preferred providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . The deductible does not apply to outpatient prescription drugs .
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: Tier 1: \$1,500 person/\$4,500 family Tier 2: \$2,500 person/\$7,500 family Tier 3: \$12,500 person/\$37,500 family Prescription Drugs : \$4,850 individual / \$7,200 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. There is a separate out-of-pocket limit for Prescription Drugs .
What is not included in the out-of-pocket limit?	Premiums , balance-billing charges, health care this plan doesn't cover and penalties for not obtaining prior authorization.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. For a list of preferred providers, see - Tier 1: www.keckmedicine.org or call (833) KECK-USC (833-532-5872) / Tier 2: www.anthem.com/ca or call 1-800-888-8288	This plan uses a provider network . 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 network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider Tier 1: Keck Medicine of USC (Anthem Blue Cross / Blue Card for covered persons < age 19) (You will pay the least)	Network Provider Tier 2: Anthem Blue Cross Prudent Buyer PPO / BlueCard providers	Tier 3 Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay /visit if you designate a Primary Care Physician (PCP); \$25 copay /visit if you do not designate a PCP	\$30 copay /visit if you designate a Primary Care Physician (PCP); \$40 copay /visit if you do not designate a PCP	All amounts over 50% of UCR	-----None-----
	Specialist visit	\$25 copay /visit	\$40 copay /visit	All amounts over 50% of UCR	-----None-----
	Preventive care/screening/immunization	No Charge	No Charge	All amounts over 50% of UCR	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray/blood work)	10% coinsurance	20% coinsurance	All amounts over 50% of UCR	-----None-----
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	All amounts over 50% of UCR	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at benefitplans.navitus.com/usc	Generic drugs (Tier 1)	Retail/Mail: Generic:\$5 copay /30-day supply		Retail: 50% coinsurance (of the Navitus contracted rate) Mail-order: Not Covered	Covers up to a 30-day supply (retail prescription) when using a Navitus Retail Pharmacy and exclusive specialty pharmacies Lumicera/Keck Specialty Pharmacy; 30-day supply (mail order) when using Costco Pharmacy Mail Order. No charge for oral contraceptives.
	Preferred brand drugs (Tier 2)	Retail/Mail: Brand (when no Generic is available): \$25 copay /30-day supply			
	Non-preferred brand drugs (Tier 3)	Retail/Mail: Brand (when a Generic is available): \$70 copay /30-day supply			
	Specialty drugs (Tier 4)	Generic: \$5 copay /30-day supply Brand: \$125 copay /30-day supply			

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If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	\$200 copay	\$600 copay ; plus all amounts over 50% of UCR (Plan payment is limited to \$2,700)	Prior Authorization may be required or payment may be reduced or denied.– refer to the Summary Plan Document.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	All amounts over 50% of UCR	-----None-----
If you need immediate medical attention	Emergency room care	\$200 copay	\$200 copay	\$200 copay	Emergency room care copay waived if admitted. Non- emergency use of emergency services not covered.
	Emergency medical transport	Not available	20% coinsurance	20% coinsurance	
	Urgent care	Not available	\$35 copay/visit	All amounts over 50% of UCR	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	\$300 copay/ admission	\$600 copay ; plus all amounts over 50% of UCR	Prior authorization required or payment may be reduced or denied.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	All amounts over 50% of UCR	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 copay/visit if you designate a Primary Care Physician (PCP); \$25 copay/visit if you do not designate a PCP	\$30 copay/visit if you designate a Primary Care Physician (PCP); \$40 copay/visit if you do not designate a PCP	All amounts over 50% of UCR	-----None-----
	Inpatient services	No Charge	\$300 copay/ admission	\$600 copay ; plus all amounts over 50% of UCR	Prior authorization required or payment may be reduced or denied.
If you are pregnant	Office visits	\$15 copay/visit if you designate a Primary Care Physician (PCP); \$25 copay/visit if you	\$30 copay/visit if you designate a Primary Care Physician (PCP); \$40	All amounts over 50% of UCR	-----None-----

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		do not designate a PCP	<u>copay</u> /visit if you do not designate a PCP		
	Childbirth/delivery professional services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	All amounts over 50% of UCR	-----None-----
	Childbirth/delivery facility services	No Charge (Only at USC Verdugo Hills Hospital)	\$300 <u>copay</u> /admission	\$600 <u>copay</u> ; plus all amounts over 50% of UCR	Prior Authorization required for stays exceeding those in the Newborns' and Mothers' Health Protection Act – refer to the Summary Plan Document.
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	All amounts over 50% of UCR	Maximum of 100 visits/person/ cal. yr. Prior authorization is required after ten visits.
	<u>Rehabilitation services</u>	\$25 <u>copay</u>	\$40 <u>copay</u>	All amounts over 50% of UCR	Prior authorization is required after 12 combined therapy visits or payment may be reduced or denied.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	All amounts over 50% of UCR	Maximum of 40 visits/ person/ calendar year. Not all habilitation services are covered – refer to the Summary Plan Document.
	<u>Skilled nursing care</u>	Not available	\$300 <u>copay</u> /admission	\$600 <u>copay</u> /admission	Prior authorization required or payment may be reduced or denied. Maximum of 100 days per person per calendar year.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	All amounts over 50% of UCR	Prior authorization is required when the purchase price or rental cost exceeds \$2,000 or payment may be reduced or denied.

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	Hospice services	Not available	No Charge	All amounts over 50% of UCR	Deductible waived.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	-----None-----
	Children's glasses	Not Covered	Not Covered	Not Covered	-----None-----
	Children's dental check-up	Not Covered	Not Covered	Not Covered	-----None-----

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- | | | |
|--|---|---|
| <ul style="list-style-type: none"> • Cosmetic Surgery • Dental Care • Hearing Aids (for covered persons age 26 and older) | <ul style="list-style-type: none"> • Infertility Treatment • Long Term Care • Private Duty Nursing | <ul style="list-style-type: none"> • Weight Loss Programs • Routine Foot Care • Routine Eye Care |
|--|---|---|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | | |
|--|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric Surgery (when performed at a Center of Medical Excellence Facility) | <ul style="list-style-type: none"> • Chiropractic Care • Hearing Aids (for covered persons under age 26) | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S |
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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. For more information on your rights to continue coverage, contact the plan at 1-855-727-5267. You may also contact your state insurance department, the California Department of Insurance. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: 1-855-727-5267.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-727-5267.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-727-5267.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-727-5267.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-727-5267.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care under Tier 1. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's overall deductible](#) \$125
- [Specialist copayment](#) \$25
- [Hospital \(facility\) copay](#) \$0
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$30
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$490

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's overall deductible](#) \$125
- [Specialist copayment](#) \$25
- [Hospital \(facility\) copay](#) \$0
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$100
Copayments	\$400
Coinsurance	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$600

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's overall deductible](#) \$125
- [Specialist copayment](#) \$25
- [Hospital \(facility\) copay \(ER\)](#) \$200
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$100
Copayments	\$400
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$700

*Note: This plan does not have other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.