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 https://hconline.healthcomp.com/usc 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 https://www.healthcare.gov/sbc-glossary or call 1-855-727-5267 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$125/Individual $375/Family	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.
Are there services covered before you meet your deductible?	Yes. All services subject to a copay and preventive care.	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 $1,500/Individual $4,500/Family --- Prescription drug $2,000/Individual $4,000/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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	You must use network providers, except in the event of an emergency. See https://hconline.healthcomp.com/usc or call 1-855-727-5267 for a list of network providers.	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 may self-refer to any provider within the USC Trojan Care EPO Plan Network.	You can see the network 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 (You will pay the least)	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.	Not covered	Designation of a Primary Care Physician is required for the lowest copay.
	Specialist visit	$25 copay/visit	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	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	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.benefitplans.navitus.com/usc	Generic drugs	**Retail & Mail Order** $5 copay / prescription	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.
	Preferred brand drugs	**Retail & Mail Order –** Brand (when no generic is available) $25 copay / prescription	Not covered	
	Non-preferred brand drugs	**Retail & Mail Order** Brand (when a Generic is available) $70 copay / prescription	Not covered	
	Specialty drugs	**Generic** $5 copay / prescription **Brand** $125 copay / prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay/visit	Not covered	Prior authorization may be required or payment may be reduced or denied – refer to the Summary Plan Document.
	Physician/surgeon fees	10% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Copay waived if admitted. Non-emergency use of emergency services not covered.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$35 copay/visit	$35 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/admission	Not covered	Prior authorization required or payment may be reduced or denied.
	Physician/surgeon fees	10% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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.	Not covered	Designation of a Primary Care Physician is required for the lowest copay.
	Inpatient services	$100 copay/admission	Not covered	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 do not designate a PCP.	Not covered	Designation of a Primary Care Physician is required for the lowest copay. Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	Not covered	Prior authorization is only required for stay exceeding 48 hours after delivery (or 96 hours after C-section.).
	Childbirth/delivery facility services	$100 copay/admission	Not covered	Prior authorization is only required for stay exceeding 48 hours after delivery (or 96 hours after C-section.)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	Limited to 100 visits per person per Calendar Year. Prior authorization is required after ten visits.
	Rehabilitation services	$25 copay/visit **Inpatient** 10% coinsurance	Not covered	Prior authorization is required after 20 physical or occupational therapy visits or payment may be reduced or denied.
	Habilitation services	10% coinsurance	Not covered	Limited to 40 visits per person per Calendar Year. Not all habilitation services are covered – refer to the Summary Plan Document. Limits do not apply to autism spectrum disorders.
	Skilled nursing care	$100 copay/admission	Not covered	Prior authorization required or payment may be reduced or denied. Limited to 100 days per person per Calendar Year.
	Durable medical equipment	10% coinsurance	Not covered	Prior authorization is required when the purchase price or rental cost exceeds $2,000 or payment may be reduced or denied.
	Hospice services	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Must enroll in separate vision plan.
	Children's glasses	Not covered	Not covered	Must enroll in separate vision plan.
	Children's dental check-up	Not covered	Not covered	Must enroll in separate dental plan.

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.)

- Cosmetic Surgery
- Dental Care
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Eye Care
- Routine Foot Care
- Weight Loss Programs

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

- Acupuncture
- Bariatric Surgery (when performed at a Center of Medical Excellence Facility)
- Chiropractic Care
- Hearing Aids
- Infertility Treatment

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/healthreform. 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 on how 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: HealthComp Administrators at 1-855-727-5267 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the 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, kwiijigo 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. 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) copayment** **$100**
- **Other (Tests) 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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$125
Copayments	$100
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$785**

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) copayment** **$100**
- **Other (Brand drugs) copayment** **$25**

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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$125
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,145**

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

- **The plan's overall deductible** **$125**
- **Specialist copayment** **$25**
- **Hospital (ER) copayment** **$150**
- **Other (Physical Therapy) copayment** **$25**

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**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$125
Copayments	$300
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$445**

The plan would be responsible for the other costs of these EXAMPLE covered services.