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.HCOnline.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/healthform or call 1-877-552-7247 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	**Keck Medicine of USC and USC Care Medical Group** None	**Anthem PPO** $500/Employee only $750/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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Tier 1 emergency room and urgent care; inpatient and outpatient facility fees; hospital physician/surgeon fees; preventive services; rehabilitative services; and skilled nursing 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** $5,000/Employee-only $10,000/Family		The out-of-pocket limit is the most you could pay in a year for covered services. Medical: If you have other family members in this plan, the overall family out-of-pocket limit must be met. Prescription drug: 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.
	Prescription drug $1,600/Individual $3,200/Family		
What is not included in the out-of-pocket limit?	Copayments on certain services, amounts applied to deductible, balance-billing charges, amounts over usual, customary and reasonable, services rendered by non-network providers, penalties for failure to receive prior authorization, and health care this plan doesn't cover.		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. **Tier 1: www.keckmedicine.org** **Tier 2: www.anthem.com/ca or call 1-800-274-7767**	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 Keck Medicine and USC Care Medical Group 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
		Keck Medicine of USC/USC Care Med Group (USCCMG) Network Tier 1 Provider (You will pay the least)	Anthem Network Tier 2 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	$10/visit	$25/visit Deductible waived	None
	Specialist visit	$10/visit	$25/visit Deductible waived	None
	Preventive care/screening/ immunization	No charge	No charge Deductible waived	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)	No charge up to initial $400; 10% coinsurance thereafter	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge up to initial $400; 10% coinsurance thereafter	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Keck Medicine of USC/USC Care Med Group (USCCMG) Network Tier 1 Provider (You will pay the least)	Anthem Network Tier 2 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 www.navitus.com	Generic drugs	**Retail** 10% coinsurance ($5 max)	**Retail & Mail** 20% coinsurance ($10 max)	Tier 1: Keck Medicine Pharmacies (up to 90-day supply) Tier 2: Navitus/Mail Order Network Pharmacies (Retail: 30-day & Mail Order 90-day supply) Specialty Drugs: up to 30 day supply No coverage for prescriptions filled at a non-network pharmacy.
	Preferred brand drugs	**Retail** 20% coinsurance	**Retail & Mail** 30% coinsurance	
	Non-preferred brand drugs	**Retail** 30% coinsurance	**Retail & Mail** 50% coinsurance	
	Specialty drugs	Same as non-specialty Tier 1		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	**ER** $75/visit **Non-ER** $75/visit + 10% coinsurance	**ER** $100/visit Deductible waived **Non-ER** $100/visit + 30% coinsurance	Prior authorization required if admitted.
	Emergency medical transportation	Not available	20% coinsurance	None
	Urgent care	Not available	$50/visit Deductible waived	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	Prior authorization required.
	Physician/surgeon fees	No charge	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Keck Medicine of USC/USC Care Med Group (USCCMG) Network Tier 1 Provider (You will pay the least)	Anthem Network Tier 2 Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10/visit (USCCMG only)	$25/visit Deductible waived	None
	Inpatient services	No charge	30% coinsurance	Prior authorization required.
If you are pregnant	Office visits	$10/visit (USCCMG only)	$25/visit Deductible waived	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	No charge	30% coinsurance	
	Childbirth/delivery facility services	No charge	30% coinsurance	Prior authorization is only required for stay exceeding 48 hours after delivery (or 96 hours after C-section.).
If you need help recovering or have other special health needs	Home health care	30% coinsurance	30% coinsurance	Prior authorization required. Limited to 50 visits per year.
	Rehabilitation services	Physical & Occupational Therapy 10% coinsurance	30% coinsurance	Prior authorization required for inpatient care.
		Other therapies No charge		
	Habilitation services	10% coinsurance	30% coinsurance	None
	Skilled nursing care	No charge	30% coinsurance	Prior authorization required. Limited to 120 days.
	Durable medical equipment	10% coinsurance	30% coinsurance	None
	Hospice services	20% coinsurance	20% coinsurance	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Keck Medicine of USC/USC Care Med Group (USCCMG) Network Tier 1 Provider (You will pay the least)	Anthem Network Tier 2 Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Vision coverage is offered through VSP.
	Children's glasses	Not covered	Not covered	Vision coverage is offered through VSP.
	Children's dental check-up	Not covered	Not covered	Dental coverage is offered through Delta Dental.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Eye Care (Adult)
- 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.)

- Bariatric Surgery (when performed Tier 1 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 at 1-855-727-5267 or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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	**$0**
Specialist copayment	**$10**
Hospital (facility) copayment	**$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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$60**

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

The plan's overall deductible	**$0**
Specialist copayment	**$10**
Hospital (facility) copayment	**$0**
Other (Brand drugs) coinsurance	**20%**

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	$0
Copayments	$100
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

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

The plan's overall deductible	**$0**
Specialist copayment	**$10**
Hospital (ER) copayment	**$75**
Other (Physical therapy) 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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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