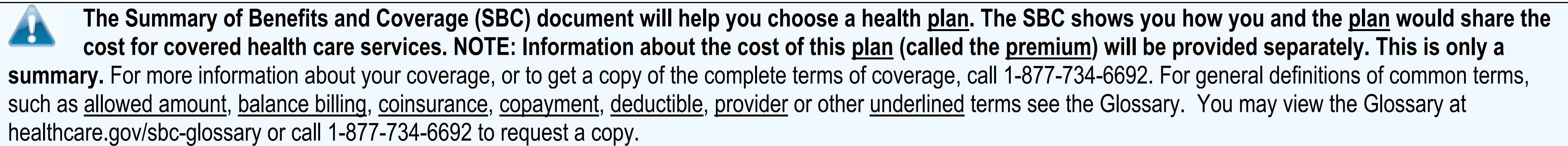

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-877-734-6692. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary. You may view the Glossary at healthcare.gov/sbc-glossary or call 1-877-734-6692 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1--$0 Tiers 2 & 3—Single Plan: $1,000 employee Family Plan: $1,000 person/$2,000 family Tier 4— Single Plan: $1,000 employee Family Plan: $1,000 person/$2,000 family	Tier 1---See the Common Medical Events chart below for your costs for services this plan covers. Tiers 2, 3 & 4---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?	Tier 1--Not applicable. Tiers 2 & 3—Yes. Preventive services and physician office visits are some of the services covered before you meet your deductible.	Tier 1---Not applicable. Tiers 2 & 3---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 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?	Tier 1—Single Plan: $500 employee Family Plan: $500 person/$1,000 family Tiers 2 & 3—Single Plan: $5,500 employee Family Plan: $5,500 person/$11,000 family Tier 4—Single Plan: $5,500 employee Family Plan: $5,500 person/$11,000 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 is met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges and health care this plan doesn't cover.	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. See hpiTPA.com or call 1-877-734-6692 for a list of network providers.	You pay the least if you use Tier 1 provider. You may pay more if you use Tier 2 or 3 provider. You pay the most if you use Tier 4 provider and you might receive a bill from a provider for difference between provider's charge and what your plan pays (balance-billing). 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 see a specialist you choose without a referral.

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
		USC Arcadia Hospital Services & Providers [Tier 1]	Participating Physician Providers & Facilities [Tier 2]	Non-Participating Facilities [Tier 3]	Non-Participating Physician Providers [Tier 4]	
		(You pay the least)	(You may pay more)		(You 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	$30 copay/visit; deductible waived	Not applicable	$30 copay/visit; deductible waived	You may have to pay for services that aren't preventive. Ask provider if services are preventive. Then check what your plan will pay. May require preauthorization.
	Specialist visit	$30 copay/visit	$55 copay/visit; deductible waived	Not applicable	$55 copay/visit; deductible waived	
	Preventive care/ Screening/Immunization	No charge	No charge; deductible waived			
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	30% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	30% coinsurance	40% coinsurance	Preauthorization required.
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at hpiTPA.com	Generic drugs— Retail Mail Order	$10 copay/prescription $20 copay/prescription			Not covered	Prescription drug out-of-pocket limits are $1,350 per person up to $2,700 per family. Deductible waived. Covers up to 34-day supply (retail); 90-day supply (mail order).
	Preferred brand drugs— Retail Mail Order	$25 copay/prescription $50 copay/prescription				
	Non-preferred brand drugs—	Not covered				
	Specialty drugs— Retail Mail Order	20% coinsurance ($150 max/prescription) Available through Accredo Specialty Mail Pharmacy				
	Smart90 Maintenance Medication Program---You must obtain maintenance drugs in 31-90-day supplies from Express Scripts Mail Service Pharmacy or Walgreens after 2nd fill at retail.					
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery ctr)	No charge	20% coinsurance	20% coinsurance	40% coinsurance	Preauthorization required.
	Physician/surgeon fees	No charge	20% coinsurance	Not applicable	40% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit; deductible waived			Copay waived if admitted
	Emergency medical transportation	Not available	Not available	20% coinsurance		None
	Urgent care	Not available	$30 copay/visit; deductible waived			None
Preauthorization is required for hospital admissions & all Facility-Based Services provided at a hospital, surgical center, outpatient facility or dialysis center.						

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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
		USC Arcadia Hospital Services & Providers [Tier 1]	Participating Physician Providers & Facilities [Tier 2]	Non-Participating Facilities [Tier 3]	Non-Participating Physician Providers [Tier 4]	
		(You pay the least)	(You may pay more)		(You pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge; deductible waived	20% coinsurance	Not applicable	Preauthorization required.
	Physician/surgeon fees	No charge	20% coinsurance	Not applicable	40% coinsurance	
If you need mental health, behavioral health or substance abuse services	Outpatient services— Office Visit	$15 copay/visit	$30 copay/visit; deductible waived	20% coinsurance	$30 copay/visit; deductible waived	Preauthorization required for Intensive outpatient treatment & Inpatient services.
	Intensive Outpatient Treatment	Not available	No charge; deductible waived			
	Inpatient services— Facility	Not available	Not available	No charge; deductible waived	Not applicable	
	Physician	Not available	deductible only	Not applicable	40% coinsurance	
If you are pregnant	Office visits— Prenatal Services	No charge	No charge; deductible waived	Not applicable	No charge; deductible waived	Maternity care may include tests & services described elsewhere in SBC (i.e. ultrasound). Requires preauthorization prior to delivery.
	Postnatal Services	$15 copay/visit	$30 copay/visit; deductible waived	Not applicable	$30 copay/visit; deductible waived	
	Childbirth/delivery professional services	No charge	20% coinsurance	Not applicable	40% coinsurance	
	Childbirth/delivery facility services	No charge	No charge; deductible waived	20% coinsurance	Not applicable	
If you need help recovering or have other special health needs	Home health care	Not available	20% coinsurance	Not applicable	40% coinsurance	Preauthorization required.
	Rehabilitation Services Inpatient	No charge	No charge; deductible waived	20% coinsurance	Not applicable	Preauthorization required for Inpatient, after 24 Occupational therapy visits & after 13 Physical therapy visits. 24 visits/yr for Speech therapy.
	Outpatient	$15 copay/visit (No charge for Occupational or Physical therapy at USC Arcadia Hospital)	$30 copay/visit; deductible waived	Not applicable	$30 copay/visit; deductible waived	

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: USC Arcadia Hospital Services & Providers [Tier 1] (You pay the least)	Participating Physician Providers & Facilities [Tier 2] (You may pay more)	Non-Participating Facilities [Tier 3] (You may pay more)	Non-Participating Physician Providers [Tier 4] (You pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs (continued)	Habilitation services— Early Intervention Developmental Delay	No covered Not available	Not covered 20% coinsurance	No covered Not applicable	Not covered 40% coinsurance	n/a Preauthorization & visit limits based on services provided.
	Skilled nursing care	Not available	Not available	20% coinsurance	Not applicable	Preauthorization required.
	Durable medical equipment	Not available	30% coinsurance	Not applicable	40% coinsurance	Preauthorization required for insulin pumps & supplies, equipment over $2,500 & Out-Of-Network Providers
	Hospice services— Inpatient Outpatient	Not available Not available	Not available 20% coinsurance	20% coinsurance Not applicable	Not applicable 40% coinsurance	Preauthorization required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered	n/a
	Children's glasses	Not covered	Not covered	Not covered	Not covered	n/a
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered	n/a

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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
- Habilitation Services – Early Intervention
- Non-emergency care when traveling outside U.S.
- Routine eye care (child & adult)
- Cosmetic surgery
- Infertility treatment
- Non-preferred brand name drugs
- Routine foot care
- Dental care (routine child & adult)
- Long term care
- Private Duty Nursing
- 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
- Chiropractic care (12 visits/yr)
- Hearing aids (1 aid/ear/24 months)

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 the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-EBSA (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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact the plan at 1-877-734-6692. You may also contact the U.S. Department of Labor, 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 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 1-877-734-6692
Portuguese (Português): De assistència em Portuguès, ligue 1-877-734-6692
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-734-6692

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

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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** **$30**
- **Hospital (facility)** ***no charge***
- **Other** ***no charge***

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	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

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

- **Tiers 2 & 3 deductible*** **$1,000**
- **Specialist copayment** **$30**
- **Hospital (facility)** ***no charge***
- **Other coinsurance** **30%**

***Tiers 2 & 3 deductible applies since DME is not available Tier 1**

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	$800
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

- **Tiers 2 & 3 deductible*** **$1,000**
- **Specialist copayment** **$30**
- **Hospital (facility)** ***no charge***
- **Other** ***no charge***

***Tiers 2 & 3 deductible applies since ambulance and DME not available Tier 1**

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	$1,000
Copayments	$200
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,270**

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