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?	Individual: $100 Family Maximum: $300	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.	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: $1,000 individual / $3,000 family; Prescription Drugs: $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.
Will you pay less if you use a network provider?	You must use network providers, except in the event of an emergency. See hconline.healthcomp.com/uscprovidersearch or call 1-877-552-7247 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 EPO Plus 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	$10 copay/visit if you designate a Primary Care Physician (PCP); $20 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	$20 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	
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	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		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay	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	Emergency room care	$150 copay	$150 copay	Emergency room care copay waived if

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)	
immediate medical attention	Emergency medical transportation	No Charge	No Charge	admitted. Non-emergency use of emergency services not covered.
	Urgent care	$35 copay/visit	$35 copay/visit	
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-------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/visit if you designate a Primary Care Physician (PCP); $20 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	$10 copay/visit if you designate a Primary Care Physician (PCP); $20 copay/visit if you do not designate a PCP	Not Covered	Designation of a Primary Care Physician is required for the lowest copay.
	Childbirth/delivery professional services	10% coinsurance	Not Covered	-------None-------
	Childbirth/delivery facility services	$100 copay/admission	Not Covered	Prior Authorization required for stays exceeding those outlined 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	Home health care	10% coinsurance	Not Covered	Maximum of 100 visits/person/calendar year. Prior authorization is required after ten visits.
	Rehabilitation services	$20 copay/visit	Not Covered	Prior authorization is required after 12 combined therapy visits or payment may be reduced or denied.
	Habilitation services	10% coinsurance	Not Covered	Maximum of 40 visits/ person/calendar year. Not all habilitation services are covered – refer to the Summary Plan Document.
	Skilled nursing care	$100 copay/admission	Not Covered	Prior authorization required or payment may be reduced or denied. Maximum of 100 days per person per calendar year.
	Durable medical equipment	10% coinsurance	Not Covered	Prior authorization is required when the

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)	
				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	-------None-------
	Children's glasses	Not Covered	Not Covered	-------None-------
	Children's dental check-up	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.)

- Cosmetic Surgery
- Dental Care
- Hearing Aids (for covered persons age 26 and older)
- Infertility Treatment
- 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 (for covered persons under age 26)

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, 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	$100
Specialist copayment	$20
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

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

The plan's overall deductible	$100
Specialist copayment	$20
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$100
Copayments	$400
Coinsurance	$80
What isn't covered	
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	$100
Specialist copayment	$20
Hospital (facility) copay (ER)	$150
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$100
Copayments	$300
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$440**

*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.

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