




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, visit [wellaway.com/en/studentplans/](http://wellaway.com/en/studentplans/) or by calling 1-855-773-7810. 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.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-855-773-7810 to request a copy.

| Important Questions   | Answers   | Why This Matters:   |
|---|---|---|
| What is the overall <a href="#">deductible</a> ?                                | For each <a href="#">plan</a> year, USC Designated <a href="#">Provider</a> and In- <a href="#">Network</a> : individual \$250 (combined) <a href="#">Out-of-network</a> : individual \$500                   | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Prescription Drugs</a> ; in- <a href="#">network</a> office visits & <a href="#">Preventive care</a> are covered before you meet your <a href="#">deductible</a> .                           | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .   |
| Are there other <a href="#">deductibles</a> for specific services?              | No.   | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | USC Designated <a href="#">Provider</a> and In- <a href="#">Network</a> : individual \$5,500 (combined) <a href="#">Out-of-network</a> individual \$5,500   | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover & penalties for failure to obtain <a href="#">pre-authorization</a> for services. | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.wellaway.com">www.wellaway.com</a> or call 1-855-773-7810 for a list of <a href="#">network providers</a> .  | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.   | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .  |

 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 Designated Provider<br>(You will pay the least)                               | In-Network Provider<br>(You will pay more)  | Out-of-Network Provider<br>(You will pay the most)  |   |
| If you visit a health care <a href="#">provider's</a> office or clinic   | Primary care visit to treat an injury or illness       | No charge   | \$30 <a href="#">copay</a> /visit, <a href="#">deductible</a> doesn't apply       | 40% <a href="#">coinsurance</a>   | None  |
|  | <a href="#">Specialist</a> visit                       | No charge   | \$30 <a href="#">copay</a> /visit <a href="#">deductible</a> doesn't apply        | 40% <a href="#">coinsurance</a>   | None  |
|  | <a href="#">Preventive care/screening/immunization</a> | No charge   | No charge   | 40% <a href="#">coinsurance</a>   | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.   |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 10% <a href="#">coinsurance</a>   | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   | None  |
|  | Imaging (CT/PET scans, MRIs)                           | 10% <a href="#">coinsurance</a>   | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   | <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in denied coverage or up to \$500 penalty.   |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.wellaway.com</a> | Generic drugs  | \$5 <a href="#">copay</a> /prescription <a href="#">deductible</a> doesn't apply  | \$5 <a href="#">copay</a> /prescription <a href="#">deductible</a> doesn't apply  | 40% <a href="#">coinsurance</a> after \$5 <a href="#">copay</a> /prescription <a href="#">deductible</a> doesn't apply  | Covers 30-day supply (retail), 31-90 day supply may be available. Includes contraceptive drugs & devices obtainable from a pharmacy. Review your <a href="#">formulary</a> for prescriptions requiring precertification or step therapy for coverage. Prescriptions above \$250 require <a href="#">Preauthorization</a> . Failure to obtain <a href="#">preauthorization</a> may result in denied coverage or up to \$500 penalty. |
|  | Preferred brand drugs                                  | \$50 <a href="#">copay</a> /prescription <a href="#">deductible</a> doesn't apply | \$50 <a href="#">copay</a> /prescription <a href="#">deductible</a> doesn't apply | 40% <a href="#">coinsurance</a> after \$50 <a href="#">copay</a> /prescription <a href="#">deductible</a> doesn't apply |   |
|  | Non-preferred brand drugs                              | \$75 <a href="#">copay</a> /prescription <a href="#">deductible</a> doesn't apply | \$75 <a href="#">copay</a> /prescription <a href="#">deductible</a> doesn't apply | 40% <a href="#">coinsurance</a> after \$75 <a href="#">copay</a> /prescription <a href="#">deductible</a> doesn't apply |   |
|  | <a href="#">Specialty drugs</a>                        | \$90 <a href="#">copay</a> /prescription <a href="#">deductible</a> doesn't apply | \$90 <a href="#">copay</a> /prescription <a href="#">deductible</a> doesn't apply | 40% <a href="#">coinsurance</a> after \$90 <a href="#">copay</a> /prescription <a href="#">deductible</a> doesn't apply |   |
| If you have outpatient surgery   | Facility fee (e.g., ambulatory surgery center)         | 10% <a href="#">coinsurance</a>   | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   | In-Network <a href="#">Provider</a> : services must be provided in a free-standing facility. <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in denied coverage or up to \$500 penalty.  |
|  | Physician/surgeon fees                                 | 0% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   |   |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.wellaway.com](#).

| Common Medical Event  | Services You May Need                            | What You Will Pay   |  |  | Limitations, Exceptions, & Other Important Information   |
|---|--|---|--|--|--|
|   |  | USC Designated Provider<br>(You will pay the least)   | In-Network Provider<br>(You will pay more)   | Out-of-Network Provider<br>(You will pay the most)                           |  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$200 <a href="#">copay</a> /visit (waived if admitted)   | \$200 <a href="#">copay</a> /visit (waived if admitted)  | \$200 <a href="#">copay</a> /visit (waived if admitted)                      | No coverage for non-emergency use.   |
|   | <a href="#">Emergency medical transportation</a> | 10% <a href="#">coinsurance</a>   | 20% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>  | Non-emergency transport not covered, except if preauthorized.  |
|   | <a href="#">Urgent care</a>                      | \$50 <a href="#">copay</a> /visit   | \$50 <a href="#">copay</a> /visit  | 40% <a href="#">coinsurance</a>  | None   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 10% <a href="#">coinsurance</a>   | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>  | <a href="#">Preauthorization</a> required for non-maternity/non-accidental condition. Failure to obtain <a href="#">preauthorization</a> may result in denied coverage or up to \$500 penalty.           |
|   | Physician/surgeon fees                           | 0% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>  |  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | No charge (office visit) <a href="#">deductible</a> doesn't apply<br>10% <a href="#">coinsurance</a> (other outpatient services) <a href="#">deductible</a> doesn't apply | \$30 <a href="#">copay</a> /visit (office visit) <a href="#">deductible</a> doesn't apply<br>20% <a href="#">coinsurance</a> (other outpatient services) | 40% <a href="#">coinsurance</a> (office visit and other outpatient services) | <a href="#">Preauthorization</a> required for other outpatient services and inpatient services. Failure to obtain <a href="#">preauthorization</a> may result in denied coverage or up to \$500 penalty. |
|   | Inpatient services                               | 10% <a href="#">coinsurance</a> <a href="#">deductible</a> doesn't apply  | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>  |  |
| If you are pregnant   | Office visits                                    | No charge   | No charge  | 40% <a href="#">coinsurance</a>  | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)                    |
|   | Childbirth/delivery professional services        | 10% <a href="#">coinsurance</a>   | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>  |  |
|   | Childbirth/delivery facility services            | 10% <a href="#">coinsurance</a>   | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>  |  |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | 10% <a href="#">coinsurance</a>   | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>  | Within 14 days from discharge. <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in denied coverage or up to \$500 penalty.                       |
|   | <a href="#">Rehabilitation services</a>          | 10% <a href="#">coinsurance</a>   | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>  | <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in denied coverage or up to \$500 penalty.  |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.wellaway.com](http://www.wellaway.com).

| Common Medical Event                   | Services You May Need                     | What You Will Pay                                |   |   | Limitations, Exceptions, & Other Important Information  |
|--|---|--|---|---|---|
|  |   | USC Designated Provider (You will pay the least) | In-Network Provider (You will pay more) | Out-of-Network Provider (You will pay the most) |   |
|  | <a href="#">Habilitation services</a>     | 10% <a href="#">coinsurance</a>                  | 20% <a href="#">coinsurance</a>         | 40% <a href="#">coinsurance</a>                 | <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in denied coverage or up to \$500 penalty. |
|  | <a href="#">Skilled nursing care</a>      | 10% <a href="#">coinsurance</a>                  | 20% <a href="#">coinsurance</a>         | 40% <a href="#">coinsurance</a>                 | <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in denied coverage or up to \$500 penalty. |
|  | <a href="#">Durable medical equipment</a> | 10% <a href="#">coinsurance</a>                  | 20% <a href="#">coinsurance</a>         | 40% <a href="#">coinsurance</a>                 | Limited to 1 <a href="#">durable medical equipment</a> for same/similar purpose. Excludes repairs for misuse/abuse.                                 |
|  | <a href="#">Hospice services</a>          | 10% <a href="#">coinsurance</a>                  | 20% <a href="#">coinsurance</a>         | 40% <a href="#">coinsurance</a>                 | <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in denied coverage or up to \$500 penalty. |
| If your child needs dental or eye care | Children's eye exam                       | No charge  | No charge                               | 40% <a href="#">coinsurance</a>                 | Coverage limited to one exam/ <a href="#">plan</a> year up to age 19.   |
|  | Children's glasses                        | No charge  | No charge                               | 40% <a href="#">coinsurance</a>                 | Coverage limited to one pair of glasses or lenses/ <a href="#">plan</a> year up to age 19.  |
|  | Children's dental check-up                | No charge  | No charge                               | 40% <a href="#">coinsurance</a>                 | Limited to 2 exams per policy year.   |

**Excluded Services & Other Covered Services:**

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |   |   |
|---|---|---|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Hearing aids</li> </ul>   | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Routine eye care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care-except for required diabetic care</li> <li>• Weight loss programs-except for required <a href="#">preventive services</a></li> </ul> |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)  |   |   |
|---|---|---|
| <ul style="list-style-type: none"> <li>• Acupuncture – limited to 15 visits combined with other alternative care services</li> <li>• Bariatric surgery - lifetime maximum 1 per covered person</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic care - limited to 15 visits per benefit period</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing - inpatient only</li> </ul> |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.wellaway.com](http://www.wellaway.com).

**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 Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://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: WellAway Limited at 1-855-773-7810.

**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? Not applicable.**

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 1-855-773-7810.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-773-7810.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-773-7810.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-773-7810.

*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](#) \$250
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$250          |
| <a href="#">Copayments</a>        | \$60           |
| <a href="#">Coinsurance</a>       | \$2,500        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$2,810</b> |

**Managing Joe's Type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 20%
- Other [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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$250          |
| <a href="#">Copayments</a>        | \$70           |
| <a href="#">Coinsurance</a>       | \$1,100        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$1,420</b> |

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

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

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$250        |
| <a href="#">Copayments</a>        | \$200        |
| <a href="#">Coinsurance</a>       | \$500        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$950</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.