





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 <http://home.commonspirit.org/employeecentral/mybenefits> or call 1-844-450-9450, option 1. 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 1-844-450-9450, option 1, to request a copy.


Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	In-Network <u>Provider</u> : <b>\$2,000</b> individual / <b>\$4,000</b> family per calendar year.	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. In-network <u>preventive care</u> and immunizations, office visits, emergency room visits, <u>urgent care</u> facility visits, in-network inpatient hospital facility, in-network outpatient hospital facility, and <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	In-Network <u>Provider</u> : <b>\$4,500</b> individual / <b>\$9,000</b> family per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, pre-service review penalties, <u>balance-billed charges</u> , and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.aetna-commonspirit.com">www.aetna-commonspirit.com</a> or call 1-866-925-1543 for a list of <u>network providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 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
		In-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	\$25 <u>copay</u> per <u>provider</u> per date of service; <u>Deductible</u> does not apply	Not covered	Primary Care Physicians (PCP) are defined as General and Family Practice, Internal Medicine, Midwives, OB/GYN, Pediatricians, Nurse Practitioners, and PAs.
	<u>Specialist</u> visit	\$40 <u>copay</u> per <u>provider</u> per date of service; <u>Deductible</u> does not apply	Not covered	Applies to Non-PCP <u>provider</u> types. Chiropractic services apply <u>deductible</u> and <u>coinsurance</u> .
	<u>Preventive care/screening/immunization</u>	No charge Deductible does not apply	Not covered	See <a href="http://www.healthcare.gov">www.healthcare.gov</a> for preventive care guidelines. There may be additional benefits available. See your Employer Summary Plan Description for details. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Independent Lab: No charge CommonSpirit Health OP Facility: 10% <u>coinsurance</u> Non-CommonSpirit Health OP Facility: 10% <u>coinsurance</u>	Not covered	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above. Waive coinsurance on first mammogram of the benefit period.
	Imaging (CT/PET scans, MRIs)	CommonSpirit Health OP Facility: 10% <u>coinsurance</u> Non-CommonSpirit Health OP Facility: 10% <u>coinsurance</u>	Not covered	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above.

 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
		In-Network Provider (You will pay the least)	Out-of- Network Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="http://www.optumrx.com">www.optumrx.com</a></p> <p>For specialty prescriptions, go to <a href="http://www.dignityhealth.org/arizona/locations/stjosephs/services/pharmacy">www.dignityhealth.org/arizona/locations/stjosephs/services/pharmacy</a></p>	Generic drugs	Retail: \$10 <u>copay</u> Home delivery: \$25 <u>copay</u> <u>Deductible</u> does not apply	Retail: 60% <u>coinsurance</u> <u>Deductible</u> does not apply Home delivery: N/A	<p>Covers up to a 30-day supply from an in- network retail pharmacy or a 90-day supply from a home delivery: pharmacy. If you fill a brand-name prescription when a generic equivalent is available, you will pay the brand-name <u>coinsurance</u> plus the difference between the generic and brand-name. Maintenance medications must be filled for a 90-day supply using the CommonSpirit Health home delivery pharmacy, OptumRx Home Delivery, or a Walgreens retail network pharmacy. Any combination of diabetic supplies and insulin purchased at a <u>network</u> retail pharmacy on the same day are subject to one <u>copayment</u> or the applicable <u>coinsurance</u> amount. Additional <u>copayment/ coinsurance</u> amounts will apply to any combination of supplies purchased separately from an insulin purchase. Specialty prescriptions must be processed through the CommonSpirit Health Specialty Pharmacy. If the CommonSpirit Health Specialty Pharmacy can't fill your medication, your prescription will be routed to the OptumRx Specialty Pharmacy.</p>
	Preferred brand drugs	Retail: 30% <u>coinsurance</u> \$40 min/\$110 max Home delivery: 30% <u>coinsurance</u> \$100 min/\$175 max <u>Deductible</u> does not apply	Retail: 60% <u>coinsurance</u> <u>Deductible</u> does not apply Home delivery: N/A	
	Non-preferred brand drugs	Retail: 50% <u>coinsurance</u> \$65 min/\$160 max Home delivery: 50% <u>coinsurance</u> \$160 min/\$325 max <u>Deductible</u> does not apply	Retail: 60% <u>coinsurance</u> <u>Deductible</u> does not apply Home delivery: N/A	
	<u>Specialty drugs</u>	Refer to above costs	Refer to above costs	

 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
		In-Network Provider (You will pay the least)	Out-of- Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 <u>copay</u> /visit, plus 10% <u>coinsurance</u>	Not covered	Waive <u>coinsurance</u> on first colonoscopy of the benefit period.
	Physician/surgeon fees	10% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> per facility per date of service for facility and <u>physician(s) services</u> combined <u>Deductible</u> does not apply	\$200 <u>copay</u> per facility per date of service for facility and <u>physician(s) services</u> combined <u>Deductible</u> does not apply	50% <u>coinsurance</u> applies to non-emergency medical services. For emergency medical conditions treated out-of-network, you may be balance billed. Dental treatment for accidental injury is limited to care completed within 12 months of the injury.
	<u>Emergency medical transportation</u>	No charge <u>Deductible</u> does not apply	No charge <u>Deductible</u> does not apply	Ambulance services received from an out-of-network provider may balance bill the difference in the billed amount and the allowed amount.
	<u>Urgent care</u>	\$75 <u>copay</u> per <u>provider</u> per date of service <u>Deductible</u> does not apply	\$75 <u>copay</u> per <u>provider</u> per date of service <u>Deductible</u> does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	CommonSpirit Health Facility: \$250 <u>copay</u> /admission, plus 10% <u>coinsurance</u> Non-CommonSpirit Health Facility: \$1,000 <u>copay</u> /admission, plus 10% <u>coinsurance</u>	Not covered	Reduction for failure to pre-certify out-of- <u>network</u> services is \$500 per admission.
	Physician/surgeon fees	No charge	Not covered	None

 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
		In-Network Provider (You will pay the least)	Out-of- Network Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 <u>copay</u> /office visit No charge/other outpatient services <u>Deductible</u> does not apply	Not covered	None
	Inpatient services	CommonSpirit Health Facility: \$250 <u>copay</u> /admission, plus 10% <u>coinsurance</u> Non-CommonSpirit Health Facility: \$1,000 <u>copay</u> /admission, plus 10% <u>coinsurance</u>	Not covered	Residential treatment is covered with no 24-hour nursing supervision requirement. Reduction for failure to pre-certify out-of-network services is \$500 per admission.
<b>If you are pregnant</b>	Office visits	\$25 <u>copay</u> per <u>provider</u> per date of service <u>Deductible</u> does not apply	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply to certain <u>preventive services</u> . Any in-network services that fall outside of preventive care/routine obstetric care, will pay at the most appropriate benefit in the plan document.
	Childbirth/delivery professional services	No charge	Not covered	Benefits shown reflect OB/GYN practitioner services which may be globally billed at time of delivery for pre-natal, post-natal and delivery services. Not all Services are billed globally.
	Childbirth/delivery facility services	CommonSpirit Health Facility: \$250 <u>copay</u> /admission, plus 10% <u>coinsurance</u> Non-CommonSpirit Health Facility: \$1,000 co-pay/admission, plus 10% <u>coinsurance</u>	Not covered	None

 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
		In-Network Provider (You will pay the least)	Out-of- Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	Not covered	None
	<u>Rehabilitation services</u>	\$25 <u>copay</u> /PCP visit \$40 <u>copay</u> /Specialist visit <u>Deductible</u> does not apply	Not covered	In-Network only. 60 visit limit, combination of cardiac rehab and/or all other covered rehab services.
	<u>Habilitation services</u>	\$25 <u>copay</u> /PCP visit \$40 <u>copay</u> /Specialist visit <u>Deductible</u> does not apply	Not covered	None
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	Not covered	Reduction for failure to pre-certify out-of-network services is \$500 per admission.
	<u>Durable medical equipment</u>	No charge	Not covered	One wig per calendar year is covered when related to medical condition. 2 pair of foot orthotics covered per calendar year.
	<u>Hospice services</u>	10% <u>coinsurance</u> /inpatient services No charge/outpatient services	Not covered	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
<b>If your child needs dental or eye care</b>	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
- Custodial care – in home or facility
- Dental care – Adult
- Eye exam
- Glasses
- Hearing aids
- Long-term care
- Massage therapy
- 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.)

- Acupuncture (10 visits per calendar year)
- Bariatric surgery (covered only at CommonSpirit Health facility locations)
- Chiropractic care (20 visits per calendar year)
- Infertility treatment (\$15,000 LTM, \$5,000 LTM for infertility medications, excludes some services)
- Private-duty nursing – short-term intermittent home skilled nursing

**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](http://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](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 to submit a claim, appeal, or a grievance for any reason to your plan. For information about your rights, this notice, or assistance, you can contact: CommonSpirit Health Benefits Contact Center at 1-844-450-9450, option 1; Aetna Customer Service at 1-866-925-1543. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact the program for this plan's situs state: Texas Department of Insurance at 1-800-578-4677. However, for information regarding your own state's consumer assistance program refer to [www.healthcare.gov](http://www.healthcare.gov).

### 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.

—————*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 <u>plan's overall deductible</u>	\$2,000
■ <u>Specialist copayment</u>	\$25
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,840</b>
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$300
Coinsurance	\$1,048
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,408</b>

### Managing Joe's type 2 Diabetes

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

■ The <u>plan's overall deductible</u>	\$2,000
■ <u>Primary care copayment</u>	\$25
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$7,460</b>
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$310
Coinsurance	\$509
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$2,879</b>

### Mia's Simple Fracture

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

■ The <u>plan's overall deductible</u>	\$2,000
■ <u>Emergency room copayment</u>	\$200
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$2,010</b>
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,810
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,010</b>



TTY: 711

**Language Assistance:**

For language assistance in your language call 1-888-982-3862 at no cost.

- Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
- Amharic - ለቋንቋ እገዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
- Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862
- Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) գաևգի 1-888-982-3862 առանց գնով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
- Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-982-3862 ku busa
- Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862-তে কল করুন।
- Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
- Burmese - ငွေတန်ကျခံရမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ်ဆိုပါ။
- Catalan - Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.
- Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu.
- Cherokee - ᎠᎩᎠᎵ ᎠᎵᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ 1-888-982-3862 ᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ.
- Chinese - 欲取得繁體中文語言協助，請撥打1-888-982-3862，無需付費。
- Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-888-982-3862.
- Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
- Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
- French - Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
- French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
- German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
- Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
- Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કોલ કરો.
- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei.



