




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, contact the Benefits Department at 1-866-750-0576. 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 [brmsonline.com/dignityhealth](http://brmsonline.com/dignityhealth) or call 1-866-750-0576 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>Tier 1 - Dignity Health Preferred Network:</b> Individual: \$0 / Family: \$0 <b>Tier 2 – Anthem PPO Network:</b> Individual: \$300 / Family: \$900	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	<b>Yes.</b> In-Network: Physician Office Visits, <a href="#">Preventive Services</a> and Prescription Drugs.	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> 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?	<b>No.</b>	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> ?	The Medical <a href="#">Out-of-Pocket</a> Limit is separate from the Prescription Drug <a href="#">Out-of-Pocket</a> Limit. <b>Tier 1 / Enhanced -Dignity Health Preferred Network:</b> Individual: \$1,000 / Family: \$3,000 <b>Tier 2 / In-Network – Anthem PPO Network:</b> Individual: \$2,000 / Family: \$6,000 <b>Prescription:</b> Individual \$3,850 / Family \$4,700	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> for certain services and <a href="#">premiums</a> , any amount over Usual & Customary for Out-of-Network charges that result in <a href="#">balance-billing</a> , and healthcare this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses they do not count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	<b>Yes.</b> See <a href="http://brmsonline.com/dignityhealth">brmsonline.com/dignityhealth</a> or call 1-866-750-0576 for a list of <a href="#">network providers</a> .	The <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . There is no coverage 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 provider's 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> ?	<b>No.</b>	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
		Dignity Health Preferred Network Tier 1 / Enhanced Network	Anthem PPO Network Tier 2 / In-Network	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$10 <a href="#">copay</a> /office visit	10% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$10 <a href="#">copay</a> /office visit	10% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge	No Charge	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (Lab)	No Charge	Physician's Office or Contracted Lab - No Charge Hospital/Freestanding Facility – Not Covered	No coverage for services provided at a Tier 2 Anthem PPO Network hospital or freestanding facility.
	Imaging/X-Ray (CT/PET scans, MRIs)	No Charge	Physician's Office or Contracted Lab – No Charge Hospital/Freestanding Facility – Not Covered	<a href="#">Preauthorization</a> is required. No coverage for services provided at a Tier 2 Anthem PPO Network hospital or freestanding facility.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Dignity Health Preferred Network Tier 1 / Enhanced Network	Anthem PPO Network Tier 2 / In-Network	
<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="https://app.cap-rx.com">prescription drug coverage</a> is available at <a href="https://app.cap-rx.com">https://app.cap-rx.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 (Tier 1)	\$10 <a href="#">copay</a> / retail 30 day supply \$30 <a href="#">copay</a> for up to a 90 day supply at retail \$25 <a href="#">copay</a> / home delivery		No coverage for use of out of network pharmacies.  No charge for all diabetic supplies.
	Preferred brand drugs (Tier 2)	\$20 <a href="#">copay</a> / retail 30 day supply \$60 <a href="#">copay</a> for up to a 90 day supply at retail \$50 <a href="#">copay</a> / home delivery		During the year, your prescription may change Tiers. Some prescription drugs require prior authorization, compliance with step therapy and/or may be subject to quantity limits.  Members can receive up to a 90-day supply of most maintenance medications at a CAPRx Alliance CS Network Pharmacy.
	Non-preferred brand drugs (Tier 3)	\$40 <a href="#">copay</a> / retail 30 day supply \$120 <a href="#">copay</a> for up to a 90 day supply at retail \$100 <a href="#">copay</a> / home delivery		(DAW: member pays preferred or non-preferred brand copayment for brand name plus cost difference between generic and brand name when brand name requested by member)
	<a href="#">Specialty drugs</a>	\$10 <a href="#">copay</a> / Generic \$20 <a href="#">copay</a> / Preferred brand \$40 <a href="#">copay</a> / Non-Preferred brand		Covers up to a 30-day supply.  (DAW: member pays preferred or non-preferred brand copayment for brand name plus cost difference between generic and brand name when brand name requested by member)  Specialty medications must be filled at the CommonSpirit Specialty Pharmacy or CommonSpirit Health owned pharmacy.
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	<a href="#">Preauthorization</a> is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Dignity Health Preferred Network Tier 1 / Enhanced Network	Anthem PPO Network Tier 2 / In-Network	
	Surgeon/Surgical Assistant fees	No Charge	Surgeon - 10% <a href="#">coinsurance</a> Surgical Assistant – No Charge	<a href="#">Preauthorization</a> is required.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$50 <a href="#">copay</a> / visit	\$50 <a href="#">copay</a> / visit	Copay waived if admitted to the Hospital.
	<a href="#">Emergency medical transportation</a>	No Charge	No Charge	Limited to emergent, medically necessary transportation. For emergencies only. <a href="#">Preauthorization</a> is required for air ambulance.
	<a href="#">Urgent care</a>	\$10 <a href="#">copay</a> / visit	\$10 <a href="#">copay</a> / visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	<a href="#">Preauthorization</a> is required for inpatient services.
	Physician/surgeon fees	No Charge	10% <a href="#">coinsurance</a>	None
	Surgical Assistant & Anesthesiologist Fees	No Charge	No Charge	None
If you need mental health, behavioral health, or substance abuse services	Office Visit & Outpatient services	Office - \$10 <a href="#">copay</a> / visit Outpatient – No Charge	Office - 10% <a href="#">coinsurance</a> Outpatient – No Charge	None
	Inpatient services	No Charge	No Charge	<a href="#">Preauthorization</a> is required.
If you are pregnant	Office visits	\$10 <a href="#">copay</a> / initial visit	10% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> .
	Childbirth/delivery professional services	No Charge	10% <a href="#">coinsurance</a>	Depending on the type of services, <a href="#">copay</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Dignity Health Preferred Network Tier 1 / Enhanced Network	Anthem PPO Network Tier 2 / In-Network	
	Childbirth/delivery facility services	No Charge	Not Covered	<a href="#">Preauthorization</a> is required if the stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No Charge	No Charge	<a href="#">Preauthorization</a> is required.
	<a href="#">Rehabilitation services</a>	No Charge	Freestanding/Physician Office – 10% <a href="#">coinsurance</a> Facility – Not Covered	<a href="#">Preauthorization</a> required for Inpatient.
	<a href="#">Habilitation services</a>	No Charge	Freestanding/Physician Office – 10% <a href="#">coinsurance</a> Facility – Not Covered	<a href="#">Preauthorization</a> required for inpatient.
	<a href="#">Skilled nursing care</a>	No Charge	10% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Limited to 120 visits per calendar year.
	<a href="#">Durable medical equipment</a>	No Charge	No Charge	<a href="#">Preauthorization</a> is required. Deluxe equipment is not allowed when standard equipment is available and medically adequate for the reported condition.
	<a href="#">Hospice services</a>	No Charge	No Charge	None
<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
- Dental Care (Child, Adult)
- Hearing Aids
- Weight Loss Programs
- Long Term Care
- Non-emergency care when traveling outside of the U.S.
- Private-Duty Nursing
- Routine Eye Care
- Routine Foot Care

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture
- Chiropractic Care
- Infertility Services
- Bariatric Surgery

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa). 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:

Benefit & Risk Management Services  
P.O. Box 2140  
Folsom, CA 95673

### 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 1-866-750-0576.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-750-0576.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-750-0576.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-750-0576.

*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) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$60
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$120</b>

### 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) [coinsurance](#) 0%
- Other (Tier 2 pharmacy) [copayment](#) \$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
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$670
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$730</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$10
- Emergency Room (facility) [copayment](#) \$50
- Other [coinsurance](#) 0%

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
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$80
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$80</b>

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