Scottsdale Lincoln Health Network:Health Savings Accnt Plan Coverage Period: 01/01/2015–12/31/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual + Family | Plan Type: PPO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.shc.org/benefits or www.myameriben.com or by calling **(480) 323-4540 or toll-free at (877) 898-6569 or (602) 231-8855**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**SLHN and BCBSAZ In-Network Provider**: **$1,500**/individual; **$3,000**/family **Out-of-Network Provider**: **$2,500**/individual; **$5,000**/family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, for the Medical Plan including outpatient drugs, • **SLHN and BCBSAZ In-network Provider**: **$6,450**/individual; **$12,900**/family • **Out-of-Network Provider**: **None.** Out-of-pocket is unlimited. There is a $2,500/person cost-sharing limit on specialty drugs that also accumulates to this Out-of-Pocket Limit.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you pay for health care expenses.
What is not included in the out–of–pocket limit?	For the Medical Plan including outpatient drugs: premiums, balance-billed charges, health care this plan does not cover, charges in excess of annual maximum benefits, penalty for failure to obtain precertification or penalty for failure to follow the Dispense as Written (DAW) provisions of the prescription drug benefit, and out-of-network cost-sharing (except for emergency) do not count toward the **out-of-pocket limit**.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. For a list of: • **SLHN in-network providers** see Employee Intranet/Portal or www.shc.org/resources-for-employees **or call (480) 323-4540.** • **Blue Cross Blue Shield of Arizona in-network providers, see** www.azblue.com **or call (602) 231-8855.** • **Magellan Behavioral Health in-network providers, see** www.magellanhealth.com **or call (800) 424-4138.**	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 in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a SLHN In-Network Provider	Your Cost If You Use a BCBSAZ In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance.	20% coinsurance.	60% coinsurance.	Primary care = family/general practitioner, internist and pediatrician.
	Specialist visit	10% coinsurance.	20% coinsurance.	60% coinsurance.	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a SLHN In-Network Provider	Your Cost If You Use a BCBSAZ In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Other practitioner office visit	Not available	25% coinsurance.	25% coinsurance.	Alternative Healthcare including chiropractic, acupuncture, naturopathic services: the first $750/year payable at the usual coinsurance thereafter you pay 90% coinsurance.
	Preventive care/screening/ immunization	No charge.	No charge.	Not covered.	Plan covers preventive services and supplies required by the Health Reform law, with age and frequency guidelines applied.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance.	50% coinsurance.	Lab: Not covered. X-ray: 60% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	10% coinsurance.	50% coinsurance.	60% coinsurance.	Certain imaging tests require precertification.
If you need drugs to treat your illness or condition More	Generic drugs	**When using a network pharmacy location, after deductible met:** Retail Pharmacy for 30-day supply: $7 copay (unless for maintenance* drugs, then $5 copay). Retail/Mail Order for 90-day supply: $17.50 copay (unless for maintenance* drugs*, then $15 copay). Prescription contraceptives: No charge for generic drugs.		Not covered.	*Maintenance drug benefit is limited to drugs to treat asthma, diabetes, hypertension, and cardiac conditions. Some prescriptions need preapproval, quantity limits or step therapy requirements.

Common Medical Event	Services You May Need	Your Cost If You Use a SLHN In-Network Provider	Your Cost If You Use a BCBSAZ In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Preferred brand drugs	**When using a network pharmacy location after deductible met:** Retail Pharmacy for 30-day supply: 35% coinsurance with a minimum of $40 and maximum of $100. Retail/Mail Order for 90-day supply: 35% coinsurance with a minimum of $100 and maximum of $250. Prescription contraceptives: No charge for brand drug if generic drug is medically inappropriate.		Not covered.	Some prescriptions need pre-approval, quantity limits or step therapy requirements. **Dispense as Written (DAW) penalty**: If you purchase a brand drug when a generic drug is available you pay the brand drug cost-sharing plus the difference in cost between the brand drug and generic drug and the difference is a penalty that does not apply toward your out-of-pocket maximum.
	Non-preferred brand drugs	**When using a network pharmacy location after deductible met:** Retail Pharmacy for 30-day supply: 60% coinsurance with a minimum of $125. Retail/Mail Order for 90-day supply: Not covered.		Not covered.	
	Specialty drugs	Up to a 30-day supply, you pay 30% with minimum $60 and maximum of $150. Specialty drugs have a copayment maximum of $2,500 per year per covered member.		Not covered.	Call **Avella at 877-546-5779** for preapproval.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance.	50% coinsurance.	60% coinsurance.	Outpatient surgery requires precertification.
	Physician/surgeon fees	10% coinsurance.	30% coinsurance.	Anesthesia: 30% coinsurance, all others 60% coinsurance.	---none---
If you need immediate medical attention	Emergency room services	True emergency: 20% coinsurance.	True emergency: 20% coinsurance.	True emergency: 20% coinsurance.	50% coinsurance for non-emergency ER visit.
	Emergency medical transportation	25% coinsurance.	25% coinsurance.	25% coinsurance	Out-of-network ambulance applies to out-of-pocket limit.
	Urgent care	10% coinsurance.	20% coinsurance.	60% coinsurance.	Stat Drs online urgent care 24/7: 50% coinsurance after deductible met
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance.	50% coinsurance	60% coinsurance	Elective hospital admission requires precertification.

Common Medical Event	Services You May Need	Your Cost If You Use a SLHN In-Network Provider	Your Cost If You Use a BCBSAZ In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Physician/ surgeon fee	10% coinsurance.	30% coinsurance.	Anesthesia: 30% coinsurance, all others 60% coinsurance.	Coinsurance is 30% if use BCBSAZ specialist
If you have mental health, behavioral health, or substance abuse needs	Mental/ Behavioral health outpatient services	Using a **Magellan** Health Provider: 20% coinsurance.		60% coinsurance of allowed amount.	Outpatient visits to an out-of-network provider may be subject to retrospective review for medical necessity.
	Mental/ Behavioral health inpatient services	Using a **Magellan** Inpatient Hospital, Partial Hospitalization or Residential Facility: 10% coinsurance.		60% coinsurance of allowed amount.	Elective hospital admission, partial hospitalization and residential facility requires precertification.
	Substance use disorder outpatient services	Using a **Magellan** Health Provider: 20% coinsurance.		60% coinsurance of allowed amount.	Outpatient visits to an out-of-network provider may be subject to retrospective review for medical necessity.
	Substance use disorder inpatient services	Using a **Magellan** Inpatient Hospital, Partial Hospitalization or Residential Facility: 10% coinsurance.		60% coinsurance of allowed amount.	Elective hospital admission, partial hospitalization and residential facility requires precertification.
If you are pregnant	Prenatal and postnatal care	First visit to confirm pregnancy: 10% coinsurance, thereafter no charge for prenatal & postnatal office visits.	First visit to confirm pregnancy: 20% coinsurance, thereafter no charge for prenatal & postnatal office visits.	60% coinsurance.	---none---
	Delivery and all inpatient services	10% coinsurance.	Hospital: 50% coinsurance. Physician: 30% coinsurance.	60% coinsurance.	Preapproval if admit is more than 48 hours for vaginal delivery or 96 hours for C-section.

Common Medical Event	Services You May Need	Your Cost If You Use a SLHN In-Network Provider	Your Cost If You Use a BCBSAZ In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance.	20% coinsurance.	60% coinsurance.	Max. benefit 60 visits/year. Pre-certify if not using SLHN provider.
	Rehabilitation services	10% coinsurance.	50% coinsurance.	60% coinsurance.	Outpatient physical, occup. & speech therapy max. 60 visit/yr. combined. Precertify speech therapy and inpatient rehab. Inpatient rehab max. 120 days/yr.
	Habilitation services	Not covered.	Not covered.	Not covered.	You pay 100% of the expenses.
	Skilled nursing care	25% coinsurance.	25% coinsurance.	60% coinsurance.	Max. benefit 120 days per year.
	Durable medical equipment	No charge for breast pumps and supplies, all others 25% coinsurance.	No charge for breast pumps and supplies, all others 25% coinsurance.	60% coinsurance.	Certain equipment requires precertification.
	Hospice service	20% coinsurance.	20% coinsurance.	60% coinsurance.	Covered if terminally ill.
If your child needs dental or eye care	Eye exam	No charge during a preventive care office visit.	No charge during a PCP preventive care office visit.	Not covered.	Covered for child up to 26 yrs.
	Glasses	Not covered.	Not covered.	Not covered.	You pay 100% of the expense.
	Dental check-up	Not covered.	Not covered.	Not covered.	You pay 100% of the expense.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult) (Child)
- Eyeglasses
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult) (Child)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture, chiropractic and naturopathic (payable at usual cost-sharing to $750/year then you pay 90% coinsurance as part of combined Alternative Healthcare services).
- Bariatric Surgery (payable only if using the Scottsdale Healthcare Bariatric Center).
- Hearing aids (payable at the usual cost-sharing up to $2,000/ear every 3 years, then you pay 90% coinsurance).
- Infertility treatment (payable at usual cost-sharing to $1,500/person per year then you pay 90% coinsurance, plus for fertility drugs the plan pays four 30-day fills/person/yr).
- Routine foot care payable when treating diabetic (metabolic) or vascular insufficiency of the feet.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (480) 323-4540 or toll-free at (877) 898-6569 or (602) 231-8855. You may also contact your state insurance department, the 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Scottsdale Healthcare Employee Benefits Department at (480) 323-4540. 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.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (602) 231-8855.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (602) 231-8855.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,520
- **Patient pays** $2,020

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$0
Coinsurance	$480
Limits or exclusions	$30
Total	**$2,020**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,290
- **Patient pays** $2,110

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Copays	$230
Coinsurance	$300
Limits or exclusions	$80
Total	**$2,110**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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