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 National) 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, call 1-877-217-7800. 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.umr.com or call 1-877-217-7800 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier One Dignity Health Preferred Network - **$250** person / **$750** family Tier Two Out-of-Network - **$500** person / **$1,500** family Does not apply to copayments and services listed below as "No Charge" unless noted otherwise in Limitations & Exceptions column.	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 services covered before you meet your deductible?	Yes	All preventive services defined by the Affordable Care Act are covered without having to pay a copayment or co-insurance or meet a deductible. This applies only when services are delivered by a network provider. A complete list of preventive services can be found at 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?	Yes. Tier One - **$4,500** person / **$9,000** family Tier Two - **$10,000** person / **$30,000** family	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 plan for health care expenses
What is not included in the out-of-pocket limit?	Penalties, premiums, balance-billed charges, and health care this plan doesn't cover.	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?	Yes. For a list of network **providers,** see **www.umr.com**. If you are unsure which network list to select, please call 1-877-217-7800.	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 terms 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 you need a referral to see a specialist?	No	

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	$30 Copay per visit	50% Coinsurance	None
	Specialist visit	$45 Copay per visit	50% Coinsurance	None
	Preventive care/screening/ immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance	50% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	50% Coinsurance	Prior authorization is required for Out-of-Network
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs	$14 Copay per prescription (retail); $20 Copay per prescription (mail order)	Not covered	**$2,100** person / **$4,200** family annual Maximum out-of-pocket per calendar year Covers up to a 1-31-day supply (retail); 1-90 day supply (mail order); 1-30 day supply (specialty) No charge all Diabetic supplies You must pay the difference in cost between a Generic drug and a Brand-name drug when generic equivalent is available
	Preferred brand drugs	$50 Copay per prescription (retail); $70 Copay per prescription (mail order)		
	Non-preferred brand drugs	$90 Copay per prescription (retail); $140 Copay per prescription (mail order)		
	Specialty drugs	25% Copay with a Minimum of $25 up to a Maximum of $100 per prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	50% Coinsurance	None
	Physician/surgeon fees	10% Coinsurance	50% Coinsurance	None
If you need immediate medical attention	Emergency room care	$250 Copay per visit	$250 Copay per visit	Copay may be waived if admitted. Non-emergency services are not covered. Emergency room service claims for non-emergency services will be denied.
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	None
	Urgent care	$50 Copay per visit	50% Coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.umr.com.com.

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 have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	50% Coinsurance	Prior authorization is required Out-of-Network
	Physician/surgeon fees	10% Coinsurance	50% Coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services: Mental/Behavioral health and Substance use disorder	$30 Copay per office visit; 10% Coinsurance other outpatient services	50% Coinsurance	Prior authorization is required Out-of-Network
	Inpatient services: Mental/Behavioral health and Substance use disorder	10% Coinsurance	50% Coinsurance	Prior authorization is required Out-of-Network
If you are pregnant	Office visits	No charge Prenatal; 10% Coinsurance Postnatal	50% Coinsurance	Deductible Waived In-network Prenatal. Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	100%		
	Childbirth/delivery facility services	10% Coinsurance	50% Coinsurance	None
If you need help recovering or have other special health needs	Home health care	$30 Copay per visit	50% Coinsurance	120 Maximum visits per calendar year; Prior authorization is required for Out-of-Network
	Rehabilitation services	$30 Copay per visit	50% Coinsurance	None
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	10% Coinsurance	50% Coinsurance	120 Maximum days per calendar year; Prior authorization is required for Out-of-Network
	Durable medical equipment	10% Coinsurance	50% Coinsurance	Prior authorization is required for Out-of-Network DME in excess of $500 for rentals or $1,500 for purchases
	Hospice services	10% Coinsurance	50% Coinsurance	None
If your child needs	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None

* For more information about limitations and exceptions, see the plan or policy document at www.umr.com.com.

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)	
dental or eye care	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- Chiropractic care
- Hearing aids
- Infertility Treatment Limited to the diagnosis and treatment of underlying medical condition
- Private-duty nursing (Outpatient care)

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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 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 1-916-631-3051
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-916-631-3051
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-916-631-3051
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-916-631-3051

* For more information about limitations and exceptions, see the plan or policy document at www.umr.com.com.

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

* For more information about limitations and exceptions, see the plan or policy document at www.umr.com.com.

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 *copay*	$45
Hospital *facility coinsurance*	10%
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	**$7500**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$725
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$975**

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 *copay*	$45
Hospital *facility coinsurance*	10%
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	**$5000**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$225
Coinsurance	$452.50
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$927.50**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$250
Specialist *copay*	$45
Hospital *facility coinsurance*	10%
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	**$6000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$225
Coinsurance	$552.50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1027.50**

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