# UMR: Dignity Health: 7670-00-411829 Arizona Preferred Plan



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 www.umr.com or by calling 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<br>Tier Two UHC Choice Plus Network: $500 person / $1,500 family | Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.<br><br>Does not apply to Copayments and services listed below as "No Charge" unless noted otherwise in Limitations & Exceptions column. |
| Are there services covered before you meet your deductible? | Yes. Preventive care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://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? | $4,000 person / $12,000 family<br>Combined between Tier 1 and Tier 2 | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out–of–pocket limit? | Copayments for certain services, penalties, deductible for out-of-network charges, premiums, balance billing 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. See www.umr.com or call 1-877-217-7800 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral. |

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 (You will pay the least) | United Health Choice Plus Network | Out of Network (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 | $20 Copay per visit; Deductible Waived | $40 Copay per visit; Deductible Waived | Not Covered | Mayo and Cancer Treatment Centers of America providers will be considered out-of-network and not covered. |
| | Specialist visit | $30 Copay per visit; Deductible Waived | $50 Copay per visit;Deductible Waived | Not Covered | Mayo and Cancer Treatment Centers of America providers will be considered out-of-network and not covered. |
| | Preventive care/screening/ immunization | No charge; Deductible Waived | No charge; Deductible Waived | Not Covered | Services rendered by any Mayo or Cancer Treatment Centers of America provider or those services received at a Banner Health facility or hospital (outside of the physician's office) will be considered out-of-network and not covered.<br><br>You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | 10% Coinsurance | 40% Coinsurance after deductible for x-ray; 10% for blood work, no deductible | Not Covered | Services rendered by any Mayo or Cancer Treatment Centers of America provider, or services received at a Banner Health facility or hospital will be considered out-of-network and not covered. |

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|---|---|---|---|---|---|
| | | Dignity Health Preferred Network (You will pay the least) | United Health Choice Plus Network | Out of Network (You will pay the most) | |
| | Imaging (CT/PET scans, MRIs) | 10% Coinsurance | 40% Coinsurance | Not Covered | Services rendered by any Mayo or Cancer Treatment Centers of America provider, or services received at a Banner Health facility or hospital will be considered out-of-network and not covered. |
| If you need drugs to treat your illness or condition.<br><br>More information about prescription drug coverage is available at www.optumrx.com. | Generic drugs (Tier 1) | Dignity Health Preferred Pharmacy Network<br>$5 Copay per prescription (retail)<br>OptumRx Network<br>$14 Copay per prescription (retail);<br>$20 Copay per prescription (mail order) | | Not Covered | No Coverage for use of Out of Network Pharmacies<br><br>During the year, your prescription may change between Tiers. Some prescription drugs are subject to quantity limits, require prior authorization and/or step therapy.<br><br>No charge for all diabetic supplies<br><br>When a brand drug is requested by the member, where there is a generic equivalent available, the member will pay the appropriate brand copayment, plus the cost difference between the brand and generic.<br><br>1-31 day supply (retail)<br>1-90 day supply (mail order);<br>1-30 day supply (specialty)<br><br>Specialty Pharmacies available are:<br>• Dignity Health Specialty Pharmacy<br>• CHI Health Specialty Pharmacy<br>• Optum Specialty Pharmacy |
| | Preferred brand drugs (Tier 2) | Dignity Health Preferred Pharmacy Network<br>$20 Copay per prescription (retail)<br>OptumRx Network<br>$50 Copay per prescription (retail);<br>$70 Copay per prescription (mail order) | | | |
| | Non-preferred brand drugs (Tier 3) | Dignity Health Preferred Pharmacy Network<br>$40 Copay per prescription (retail)<br>OptumRx Network<br>$90 Copay per prescription(retail);<br>$140 Copay per prescription(mail order) | | | |
| | Specialty drugs (Tier 4) | 25% Copay, up to a Maximum of $100 per prescription | | | |

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|---|---|---|---|---|---|
| | | Dignity Health Preferred Network (You will pay the least) | United Health Choice Plus Network | Out of Network (You will pay the most) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% Coinsurance | 40% Coinsurance | Not Covered | Services rendered by any Mayo or Cancer Treatment Centers of America provider or services received at a Banner Health facility or hospital will be considered out-of-network and not covered. |
| | Physician/surgeon fees | 10% Coinsurance | 40% Coinsurance | Not Covered | Services rendered by any Mayo or Cancer Treatment Centers of America provider, or services received at a Banner Health facility or hospital will be considered out-of-network and not covered. |
| If you need immediate medical attention | Emergency room care | $250 Copay per visit | | | Copay may be waived if admitted.<br><br>Non-emergency services are not covered. |
| | Emergency medical transportation | 10% Coinsurance | | | Deductible Waived |
| | Urgent care | $30 Copay | $75 Copay | Not Covered | Mayo, Banner Health, or Cancer Treatment Centers of America Urgent Care facilities are considered out-of-network and not covered. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% Coinsurance | 40% Coinsurance | Not Covered | Services rendered by any Mayo or Cancer Treatment Centers of America provider, or services received at a Banner Health facility or hospital will be considered out-of-network and not covered. |
| | Physician/surgeon fee | 10% Coinsurance | 40% Coinsurance | Not Covered | Services rendered by any Mayo or Cancer Treatment Centers of America provider, or services received at a Banner Health facility or hospital will be considered out-of-network and not covered. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Dignity Health Preferred Network (You will pay the least) | United Health Choice Plus Network | Out of Network (You will pay the most) | |
| If you have mental health, behavioral health, or substance abuse needs | Outpatient services | $20 Copay Per Office Visit<br>10% Coinsurance other outpatient services | $40 Copay Per Office Visit<br>10% Coinsurance other outpatient services | Not Covered | Deductible does not apply for office visit, however may apply for other outpatient services. Mental health and substance abuse services provided by the UnitedHealthcare Behavioral Network – even if received at a Banner Health facility – will be covered at the Preferred Network benefit level. Services rendered by Mayo and Cancer Treatment Centers of America providers will be considered out-of-network and not covered. |
| | Inpatient services | 10% Coinsurance | 10% Coinsurance | Not Covered | Deductible Waived. Mental health and substance abuse services provided by the UnitedHealthcare Behavioral Network – even if received at a Banner Health facility – will be covered at the Preferred Network benefit level. Services rendered by Mayo and Cancer Treatment Centers of America providers will be considered out-of-network and not covered. |
| If you are pregnant | Office visits | Routine Prenatal No charge; Deductible Waived | Routine Prenatal No charge; deductible Waived | Not Covered | 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). Services rendered by any Mayo or Cancer Treatment Centers of America provider or received at a Banner Health facility or hospital will be considered out-of-network and not covered. |
| | Childbirth/delivery professional services | 10% Coinsurance | 40% Coinsurance | Not Covered | |
| | Childbirth/delivery facility services | 10% Coinsurance | 40% Coinsurance | Not Covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Dignity Health Preferred Network (You will pay the least) | United Health Choice Plus Network | Out of Network (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | $30 Copay Per visit | 40% Coinsurance | Not Covered | 120 Maximum visits per calendar year In-network. Prior authorization is required. If you don't get preauthorization, benefits could be reduced. Any services rendered by a Mayo or Cancer Treatment Centers of America provider, or services received in a Banner Health facility will be considered out-of-network and not covered. |
| | Rehabilitation services | $20 Copay per visit | 40% Coinsurance | Not covered | Any services rendered by a Mayo or Cancer Treatment Centers of America provider, or services received in a Banner Health facility will be considered out-of-network and not covered. |
| | Habilitation services | Not covered | Not covered | Not covered | None |
| | Skilled nursing care | 10% Coinsurance Deductible Waived | 40% Coinsurance | Not Covered | 120 Maximum days per calendar year In-network. Prior authorization is required. If you don't get preauthorization, benefits could be reduced. |
| | Durable medical equipment | 10% Coinsurance; Deductible Waived | 10% Coinsurance; Deductible Waived | Not Covered | Prior authorization is required for DME in excess of $500 for rentals or $1,500 for purchases. |
| | Hospice service | 10% Coinsurance, Deductible Waived | 10% Coinsurance, Deductible Waived | Not Covered | Any services rendered by a Mayo or Cancer Treatment Centers of America provider, or services received in a Banner Health facility will be considered out-of-network and not covered. |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | Not covered | None |
| | Children's glasses | Not covered | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | Not covered | None |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- 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
- Bariatric surgery Limitations may apply.
- Chiropractic care
- Hearing aids

**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, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or 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 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. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

**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 Standard?** 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 page.*

## 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 | $150 |
| Specialist copayment | $20 |
| 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 | $12,800 |
|---|---|

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $150 |
| Copayments | $40 |
| Coinsurance | $1,000 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Peg would pay is | $1,190 |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $150 |
| Specialist copayment | $20 |
| 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 | $7,400 |
|---|---|

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles* | $150 |
| Copayments | $500 |
| Coinsurance | $20 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| The total Joe would pay is | $690 |

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

| | |
|---|---|
| The plan's overall deductible | $150 |
| Specialist copayment | $20 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| Total Example Cost | $1,900 |
|---|---|

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles* | $150 |
| Copayments | $70 |
| Coinsurance | $90 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $310 |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.umr.com or call 1-800-826-9781.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?"" row above.