



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.umar.com](http://www.umar.com) or by calling 1-877-217-7800. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copay](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.umar.com](http://www.umar.com) or call 1-877-217-7800 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <a href="#">deductible</a> ?	Tier One Dignity Health Preferred Network: \$0 person / \$0 family Tier Two UHC Choice Plus Network: \$100 person / \$300 family Tier Three Out-of-Network: \$1,000 person / \$3,000 family	Generally, you must pay all the costs from <a href="#">providers</a> 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> .  Does not apply to Copays and services listed below as "No Charge" unless noted otherwise in Limitations & Exceptions column.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	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="#">copay</a> or <a href="#">coinsurance</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?	No.	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> ?	Tier One Dignity Health Preferred Network: \$4,000 person / \$12,000 family (Combined with Tier Two) Tier Two UHC Choice Plus Network: \$4,000 person / \$12,000 family (Combined with Tier One) Tier Three Out-of-Network: \$10,000 person / \$30,000 family	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="#">Copays</a> for certain services, penalties, deductible for out-of-network charges, <a href="#">premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.umar.com">www.umar.com</a> or call 1-877-217-7800 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most 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 <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (a <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> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All [copay](#) 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)	UHC Choice Plus Network Provider	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	\$20 Copay per visit	\$40 Copay per visit	50% Coinsurance	Mayo and Cancer Treatment Centers of America providers will be considered out-of-network.
	<a href="#">Specialist</a> visit	\$30 Copay per visit	\$50 Copay per visit	50% Coinsurance	Mayo and Cancer Treatment Centers of America providers will be considered out-of-network.
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	Not Covered	Mayo and Cancer Treatment Centers of America providers will be considered out-of-network and not covered.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-ray - \$50 Copay then 5% coinsurance Lab- 5% coinsurance, no deductible	X-ray - \$100 Copay then 30% coinsurance Lab- 5% coinsurance, no deductible	50% Coinsurance	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.
	Imaging (CT/PET scans, MRIs)	\$50 Copay for x-ray then 5% coinsurance	\$100 Copay for x-ray then 30% coinsurance	50% Coinsurance	Prior authorization is required and if not received a penalty may apply. 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.

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)	UHC Choice Plus Network Provider	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 <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>.</p>	Generic drugs (Tier 1)	<b>Dignity Health Preferred Pharmacy Network</b> \$5 Copay per prescription (retail) <b>OptumRx Network</b> \$14 Copay per prescription (retail); \$20 Copay per prescription (mail order)		Not Covered	<p>No Coverage for use of Out of Network Pharmacies</p> <p>During the year, your prescription may change between the Tiers. Some prescription drugs are subject to quantity limits, require prior authorization and/or step therapy.</p> <p>No charge for all diabetic supplies When a brand drug is requested by the member, where there is a generic equivalent available, the member will pay the appropriate brand copay, plus the cost difference between the brand and generic.</p> <p>1-31 day supply (retail) 1-90 day supply (mail order); 1-30 day supply (specialty)</p> <p><u>Specialty Pharmacies</u> available are:</p> <ul style="list-style-type: none"> <li>• Dignity Health Specialty Pharmacy</li> <li>• CHI Health Specialty Pharmacy</li> <li>• Optum Specialty Pharmacy</li> </ul>
	Preferred brand drugs (Tier 2)	<b>Dignity Health Preferred Pharmacy Network</b> \$20 Copay per prescription (retail) <b>OptumRx Network</b> \$50 Copay per prescription (retail); \$70 Copay per prescription (mail order)			
	Non-preferred brand drugs (Tier 3)	<b>Dignity Health Preferred Pharmacy Network</b> \$40 Copay per prescription (retail) <b>OptumRx Network</b> \$90 Copay per prescription (retail); \$140 Copay per prescription (mail order)			
	<a href="#">Specialty drugs</a> (Tier 4)	5% copay, no more than \$100			
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	5% after \$100 copay	30% after \$250 copay	50% Coinsurance	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.
	Physician/surgeon fees	Surgeon and Surgical Assistant: 5% Coinsurance no deductible	Surgeon and Surgical Assistant: 30% Coinsurance	Surgeon and Surgical Assistant: 50% Coinsurance	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.

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)	UHC Choice Plus Network Provider	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 copay (waived if admitted)			Non-emergency services are not covered. Emergency room service claims for non-emergency services will be denied.
	<a href="#">Emergency medical transportation</a>	5% Coinsurance, no deductible		5% Coinsurance of allowable, no deductible	---None---
	<a href="#">Urgent care</a>	\$30 copay	\$75 copay	50% of allowable	Mayo, Cancer Treatment Centers of America and Banner Health Urgent Care facilities are considered out-of-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	5% Coinsurance after \$100 copay	30% Coinsurance after \$250 copay	50% of allowable	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.
	Physician/surgeon fee	Surgeon and Surgical Assistant: 5% Coinsurance, no deductible	Surgeon and Surgical Assistant: 30% Coinsurance	Surgeon and Surgical Assistant: 50% Coinsurance	Services rendered by a Mayo or Cancer Treatment Centers of America provider or services received at a Banner Health facility or hospital, will be considered out-of-network.
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	\$20 Copay office visit; 5% Coinsurance after \$100 copay	\$40 Copay office visit; 5% Coinsurance after \$100 copay	50% Coinsurance	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 a Mayo or Cancer Treatment Centers of America provider 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)	UHC Choice Plus Network Provider	Out-of-Network Provider (You will pay the most)	
	Inpatient services	5% Coinsurance after \$100 copay		50% Coinsurance	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 a Mayo or Cancer Treatment Centers of America provider will be considered out-of-network and not covered.
If you are pregnant	Office visits	Routine Prenatal No charge, Deductible Waived Primary Care: \$20 copay; Specialist: \$30 copay	Routine Prenatal No charge, Deductible Waived Primary Care: \$40 copay Specialist: \$50 copay	50% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copay 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.
	Childbirth/delivery professional services	5% Coinsurance Postnatal	30% Coinsurance Postnatal	50% Coinsurance	
	Childbirth/delivery facility services	\$100 Copay per admission; 5% Coinsurance	\$250 Copay per admission; 30% coinsurance	50% Coinsurance	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$20 Copay per visit	30% Coinsurance	50% Coinsurance	120 Maximum visits per calendar year; Prior authorization is required. 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.
	<a href="#">Rehabilitation services</a>	\$20 Copay per visit	30% Coinsurance	50% Coinsurance	Any services rendered by a Mayo or Cancer Treatment Centers of America provider, or services received in a Banner Health facility or will be considered out-of-network.
	<a href="#">Habilitation services</a>	Not covered	Not covered	Not covered	None

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)	UHC Choice Plus Network Provider	Out-of-Network Provider (You will pay the most)	
	<a href="#">Skilled nursing care</a>	5% Coinsurance	30% Coinsurance	50% Coinsurance	<p>120 Maximum days per calendar year. Prior authorization is required. Any services rendered by a Mayo or Cancer Treatment Centers of America provider or services received at a Banner Health facility will be considered out-of-network. Prior authorization is required for DME in excess of \$500 for rentals or \$1,500 for purchases</p> <p>Prior authorization is required for DME in excess of \$500 for rentals or \$1,500 for purchases.</p> <p>Prior authorization is required. 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.</p>
	<a href="#">Durable medical equipment</a>	5% Coinsurance	5% Coinsurance Deductible Waived	50% Coinsurance	
	<a href="#">Hospice service</a>	5% Coinsurance	5% Coinsurance Deductible Waived	50% Coinsurance	
<b>If your child needs dental or eye care</b>	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)
- 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
- Private Duty Nursing (Outpatient 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](http://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](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](#). 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](http://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](#), [copays](#) 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$150
■ <a href="#">Specialist copay</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copays	\$40
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,190</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$150
■ <a href="#">Specialist copay</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$150
Copays	\$500
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$690</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$150
■ <a href="#">Specialist copay</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$150
Copays	\$70
Coinsurance	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$310</b>

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.umar.com](http://www.umar.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.