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 premier) 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 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.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 - **$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 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, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	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 **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. Out-of-pocket amounts cross-accumulate between Dignity Health Preferred Network (Tier 1) and UHC Choice Plus Network (Tier 2).
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 **preferred providers,** see www.umr.com. If you are unsure which network list to select, please call 1-877-217-7800.	This plan uses a provider network. You will pay less if you use a provider in the 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 (a 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 permission from this plan.

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

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)	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 providers will be considered out-of-network
	Specialist visit	$30 Copay per visit	$50 Copay per visit	50% Coinsurance	Mayo providers will be considered out-of-network
	Preventive care/screening/ immunization	No charge		Not covered	Mayo providers will be considered out-of-network and not covered
If you have a test	Diagnostic test (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 provider or 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 for Out-of-Network or benefit is reduced by $250 per claim. Services rendered by any Mayo provider or 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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.umr.com	Generic drugs	(31 day supply) OptumRx Network: $14 copayment when filled with generic; $50 copayment when filled with brand name when no generic equivalent is available; $50 copayment plus cost difference between brand and generic when generic equivalent is available. DH Preferred Rx Network: At the St. Joseph's McAuley and UA Cancer Center St. Joseph's Outpatient pharmacies: $5 copayment when filled with generic; $20 copayment when filled with brand if no generic available; $20 copayment plus cost difference between brand and generic when filled with brand if generic available. (90-day supply) $20 copayment when filled with generic; $70 copayment when filled with brand if no generic available; $70 plus cost difference between brand and generic when generic is available.			During the year, your prescription may change between the formulary and non-formulary. Some prescription drugs are subject to monthly quantity limits.
	Preferred brand drugs				
	Non-preferred brand drugs	(31 day supply) OptumRx Network: $90 copayment DH Preferred Rx Network: At the St. Joseph's McAuley and UA Cancer Center St. Joseph's Outpatient pharmacies: $40 copayment; $40 copayment plus cost difference between brand and generic when filled with brand if generic available. (90-day supply) $140 copayment			
	Specialty drugs	25% copayment, minimum of $25 no more than $100			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% after $100 copayment	30% after $250 copayment	50% Coinsurance	Services rendered by any Mayo provider or 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 provider or 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	Emergency room care	$250 copayment (waived if admitted)			Non-emergency services are not covered. Emergency room service claims for non-emergency services will be denied.
	Emergency medical transportation	5% Coinsurance, no deductible		5% Coinsurance, no deductible	---None---
	Urgent care	$30 copayment	$75 copayment	50% of allowable	Mayo 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 copayment	30% Coinsurance after $250 copayment	50% of allowable	Services rendered by any Mayo provider or 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 a Mayo provider will be considered out-of-network
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 Copay office visit 5% Coinsurance after $100 copayment	$40 Copay office visit 5% Coinsurance after $100 copayment	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 network benefit level.
	Inpatient services	$5% Coinsurance after $100 copayment		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 network benefit level.
If you are pregnant	Office visits	Routine Prenatal No charge, Deductible Waived Primary Care: $20 copayment Specialist: $30 copayment	Routine Prenatal No charge, Deductible Waived Primary Care: $40 copayment Specialist: $50 copayment	50% Coinsurance	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).

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)	
	Childbirth/delivery professional services	5% Coinsurance Postnatal	30% Coinsurance Postnatal	50% Coinsurance	Services rendered by any Mayo provider or received at a Banner Health facility or hospital, will be considered out-of-network
	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	Home health care	$20 Copay per visit	30% Coinsurance	50% Coinsurance	120 Maximum visits per calendar year; Prior authorization is required for Out-of-Network or benefit is reduced by $250 per claim. Any services rendered by a Mayo provider is considered out-of-network
	Rehabilitation services	$20 Copay per visit	30% Coinsurance	50% Coinsurance	Any services rendered by a Mayo provider is considered out-of-network
	Habilitation services	Not covered			Not covered
	Skilled nursing care	5% Coinsurance	30% Coinsurance	50% Coinsurance	120 Maximum days per calendar year Any services rendered by a Mayo provider or Banner Health Facility is considered out-of-network
	Durable medical equipment	5% Coinsurance	5% Coinsurance Deductible Waived	50% Coinsurance	Prior authorization is required for Out-of-Network DME in excess of $500 for rentals or $1,500 for purchases
	Hospice services	5% Coinsurance	5% Coinsurance Deductible Waived	50% Coinsurance	Any services rendered by a Mayo provider or received in a Banner Health facility will be considered out-of-network
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	

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
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)
- Weight loss programs
- Routine foot care
- Dental care (adult)

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

- Acupuncture
- Chiropractic care
- Private-duty nursing (Outpatient care)
- Bariatric surgery Limitations apply, please see
- 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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: UMR at 1-877-217-7800 or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this plan provide Minimum Essential Coverage? **This plan or policy does provide minimum essential coverage.**
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? **This health coverage does meet the minimum value standard for the benefits it provides.** 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

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

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: https://employee.dignityhealth.org/totalrewards or 1-855-475-4747.

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?"" row above.

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 *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	5%
Other *[cost sharing]*	5%

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	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$372
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$472**

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 *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	5%
Other *[cost sharing]*	5%

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	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$265
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$365**

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	5%
Other *[cost sharing]*	5%

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	**$3,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$550
Coinsurance	$150
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

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