UMR: Dignity Health: 7670-00-412517 001 DHMP Nevada EPO 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 1-866-868-2701. 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.umr.com or call 1-866-868-2701 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Tier 1 Dignity Health Preferred Network: **$0** person / **$0** family Tier 2 Sierra SHO Network/UHC Options PPO (Travel) Network: **$500** per 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. 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 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 copay 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?	**$6,000** person / **$12,000** family 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?	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/DHMPNevadaEPO**. If you are unsure which network list to select, please call 1-866-868-2701	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 a referral.

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)	SHO Network/UHC Options PPO	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	$5 Copay per visit	$40 Copay	Not Covered	Deductible Waived
	Specialist visit	$20 Copay per visit	$80 Copay	Not Covered	Deductible Waived
	Preventive care/screening/ immunization	No charge	No charge	Not Covered	Deductible Waived
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: Outpatient Radiology Center or Provider's Office: $5 copay; Dignity Health Hospital: $25 copay. Imaging: Outpatient Radiology Center: $25 copay; Dignity Health Hospital: $75 copay. PET Scan: Must be performed at a Dignity Health Hospital: $100 copay.	Outpatient Radiology Center/Hospital: Not Covered Providers Office: X-rays - 80% after deductible; Imaging/Pet Scans - Not Covered	Not Covered	Prior authorization is required for Advanced Imaging (MRI/MRA/CT/CTA/PET and Nuclear Cardiology scans)
	Diagnostic Lab	Outpatient Lab Center or Provider's Office: $5 copay	Outpatient Lab Center: Not Covered Providers Office: 80% after deductible	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)	SHO Network/UHC Options PPO	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.optumrx.com	Generic drugs (Tier 1)	$7 Copay per prescription (retail); $14 Copay per prescription (mail order)		Not Covered	If preferred brand is chosen when a generic is available, cost is copay plus the difference between preferred brand and generic.
	Preferred brand drugs (Tier 2)	$30 Copay per prescription (retail); $60 Copay per prescription (mail order)			
	Non-preferred brand drugs (Tier 3)	$50 Copay per prescription(retail); $100 Copay per prescription(mail order)			Specialty Pharmacy must be used for Specialty drugs.
	Specialty drugs (Tier 4)	Tier 1: $7 Copay per prescription Tier 2: $30 Copay per prescription Tier 3 : $50 Copay per prescription			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 Copay per visit at Surgi-Centers; $100 at Dignity Health Hospital	Not Covered, unless service not available in Tier 1 or in an emergency. If service not available in Tier 1, then service covered at Tier 1 benefit level.	Not Covered	Prior authorization is required.
	Physician/surgeon fees	$50 Copay	50% Coinsurance	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)	SHO Network/UHC Options PPO	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$75 Copay True ER	$75 Copay True ER	$75 Copay True ER	Deductible Waived Not covered: Non-True ER
	Emergency medical transportation	$50 Copay per trip	$50 Copay per trip	$50 Copay per trip	Deductible Waived
	Urgent care	$20 Copay	$20 Copay	Not Covered	Deductible Waived
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 Copay per admission	Not Covered, unless services not available in Tier 1 or in an emergency. If services not available in Tier 1, then services covered at Tier 1 benefit level.	Not Covered	Deductible Waived; Prior authorization is required.
	Physician/surgeon fee	No charge	Physician: No charge per admission; Surgeon: 50% Coinsurance	Not Covered	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$5 Copay per office visit; $50 Copay other outpatient services	$40 Copay per office visit; $50 Copay other outpatient services	Not Covered	Deductible Waived office visit; Prior authorization is required outpatient.
	Inpatient services	$100 Copay per admission	$100 copay per admission	Not Covered	Deductible Waived; Prior authorization is required.

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)	SHO Network/UHC Options PPO	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	No charge Prenatal; 20% Coinsurance Postnatal	Not Covered	Deductible Waived Prenatal
	Childbirth/delivery professional services	No charge	20% Coinsurance	Not Covered	
	Childbirth/delivery facility services	$100 Copay per admission	Not Covered, unless services not available in Tier 1 or in an emergency. If services not available in Tier 1, then services covered at Tier 1 benefit level	Not Covered	Deductible Waived
If you need help recovering or have other special health needs	Home health care	$35 Copay per visit	20% Coinsurance	Not Covered	90 Maximum visits per calendar year; Prior authorization is required.
	Rehabilitation services	$5 Copay per visit	20% Coinsurance	Not Covered	120 Maximum days per calendar year
	Habilitation services	Not covered	Not covered	Not Covered	————none————
	Skilled nursing care	$100 Copay per admission	20% Coinsurance	Not Covered	100 Maximum days per calendar year; Prior authorization is required.
	Durable medical equipment	50% Coinsurance up to a Maximum of $100	20% Coinsurance	Not Covered	Prior authorization is required for DME in excess of $500.
	Hospice service	$100 Copay per admission Inpatient; No charge Outpatient	20% Coinsurance	Not covered	Prior authorization is required.

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)	SHO Network/UHC Options PPO	Out-of-Network Provider (You will pay the most)	
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 Generally 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)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 (Tiers 1 & 2 only)
- Bariatric surgery (Tier 1 only)
- Chiropractic care (Tiers 1 & 2 only)
- Hearing aids (Tiers 1 & 2 only)

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, 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 plan's overall deductible	$150
Specialist copay	$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
Copays	$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 copay	$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
Copays	$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 copay	$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
Copays	$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.