> ⚠ **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.umr.com or by calling 1-877-217-7800.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** person / **$750** family Dignity Health Preferred Network (Tier One) **$500** person / **$1,500** family UHC Choice Plus and Out-of-Network (Tier Two & Tier Three) 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 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.
Is there an out–of–pocket limit on my expenses?	Yes. **$4,000** person / **$12,000** 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	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.	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 I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or **www.cciio.cms.gov** or call **1-877-217-7800** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-network **providers** by charging you lower **deductibles**, **Copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use the Dignity Health Preferred Network (Tier One)	Your cost if you use the UHC Choice Plus Network (Tier Two)	Your cost if you use an Out-of-Network Provider (Tier Three)	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 Copay per visit	$30 Copay per visit	Not covered	
	Specialist visit	$30 Copay per visit	$50 Copay per visit	Not covered	
	Other practitioner office visit	$30 Copay per visit	$50 Copay per visit	Not covered	20 Maximum visits per calendar year combined for manipulations and acupuncture
	Preventive care/screening/ immunization	No charge	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance	40% Coinsurance after deductible for x-ray; 10% for blood work – deductible does not apply	Not covered	
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	40% Coinsurance	Not covered	

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Common Medical Event	Services You May Need	Your cost if you use the Dignity Health Preferred Network (Tier One)	Your cost if you use the UHC Choice Plus Network (Tier Two)	Your cost if you use an Out-of-Network Provider (Tier Three)	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.umr.com.	Generic drugs	$5 Copay per prescription (St. Joseph's McAuley Pharmacy); $14 Copay per prescription (retail); $20 Copay per prescription (mail order)	Not covered		Deductible and Out-of-pocket limit applies Covers up to a 1-31 day supply (St. Joseph's McAuley Pharmacy & retail); 1-90 day supply (mail order); 1-30 day supply (specialty) No charge & Deductible Waived all diabetic supplies You must pay the difference in cost between a Generic drug and a Brand-name drug if there is a generic equivalent available
	Preferred brand drugs	$20 Copay per visit (St. Joseph's McAuley Pharmacy); $50 Copay per prescription (retail); $70 Copay per prescription (mail order)			
	Non-preferred brand drugs	$40 Copay per visit (St. Joseph's McAuley Pharmacy); $90 Copay per prescription(retail); $140 Copay per prescription(mail order)			
	Specialty drugs	$5/$20/$40 at St. Joseph's McAuley Pharmacy OptumRX: 25% Copay with a Minimum of $25 up to a Maximum of $50 per prescription			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	40% Coinsurance	Not covered	
	Physician/surgeon fees	10% Coinsurance	40% Coinsurance	Not covered	
If you need immediate	Emergency room services	$250 Copay per visit	$250 Copay per visit	$250 Copay per visit	Copay may be waived if admitted

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Common Medical Event	Services You May Need	Your cost if you use the Dignity Health Preferred Network (Tier One)	Your cost if you use the UHC Choice Plus Network (Tier Two)	Your cost if you use an Out-of-Network Provider (Tier Three)	Limitations & Exceptions
medical attention	Emergency medical transportation	10% Coinsurance	10% Coinsurance	10% Coinsurance	Deductible Waived
	Urgent care	$30 Copay per visit	$75 Copay per visit	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	40% Coinsurance	Not covered	
	Physician/surgeon fee	10% Coinsurance	40% Coinsurance	Not covered	

Common Medical Event	Services You May Need	Your cost if you use the Dignity Health Preferred Network (Tier One)	Your cost if you use the UHC Choice Plus Network (Tier Two)	Your cost if you use an Out-of-Network Provider (Tier Three)	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 Copay per office visit; 10% Coinsurance other outpatient services	$30 Copay per office visit; 10% Coinsurance other outpatient services	Not covered	Deductible does not apply for office visit, however may apply for other outpatient services
	Mental/Behavioral health inpatient services	10% Coinsurance	10% Coinsurance	Not covered	Deductible Waived
	Substance use disorder outpatient services	$20 Copay per office visit; 10% Coinsurance other outpatient services	$30 Copay per office visit; 10% Coinsurance other outpatient services	Not covered	Deductible does not apply for office visit, however may apply for other outpatient services
	Substance use disorder inpatient services	10% Coinsurance	10% Coinsurance	Not covered	Deductible Waived
If you are pregnant	Prenatal and postnatal care	No charge Prenatal; 10% Coinsurance Postnatal	No charge Prenatal; 40% Coinsurance Postnatal	Not covered	Deductible Waived Prenatal
	Delivery and all inpatient services	10% Coinsurance	40% Coinsurance	Not covered	—————none—————

Questions: Call **1-877-217-7800** or visit us at **www.umr.com**.   **Page 5 of 9**
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Common Medical Event	Services You May Need	Your cost if you use the Dignity Health Preferred Network (Tier One)	Your cost if you use the UHC Choice Plus Network (Tier Two)	Your cost if you use an Out-of-Network Provider (Tier Three)	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$30 Copay per visit	$30 Copay per visit	Not covered	120 Maximum visits per calendar year
	Rehabilitation services	$20 Copay per visit	$30 Copay per visit	Not covered	
	Habilitation services	$20 Copay per visit	$30 Copay per visit	Not covered	
	Skilled nursing care	10% Coinsurance	10% Coinsurance	Not covered	Deductible Waived; 120 Maximum days per calendar year
	Durable medical equipment	10% Coinsurance	10% Coinsurance	Not covered	Deductible Waived; Prior authorization is required for DME in excess of $500 for rentals or $1,500 for purchases
	Hospice service	10% Coinsurance	10% Coinsurance	Not covered	Deductible Waived
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered	——————none——————
	Glasses	Not covered	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u>.)		
• 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture • Bariatric surgery Limitations apply, please see bariatric surgery guidelines	• 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:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-217-7800. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can 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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy <u>does provide</u> minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage <u>does meet</u> the minimum value standard for the benefits it provides.**

Language Access Service:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-217-7800.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,640
- **Patient pays** $900

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Copays	$0
Coinsurance	$600
Limits or exclusions	$0
Total	**$900**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,700
- **Patient pays** $700

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$100
Coinsurance	$300
Limits or exclusions	$0
Total	**$700**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Costs are based on individual coverage benefit levels.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- Prescription drug costs (Prescriptions) shown in the Coverage Examples reflect information provided by the Plan's Prescription Benefits Manager.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **Copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖**No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖**No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔**Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔**Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **Copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.