



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 [Preferred](#)) 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 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.umar.com or call 1-877-217-7800 to request a copy.

Important Questions	Answers	Why this Matters:
<p>What is the overall deductible?</p>	<p>Tier One Dignity Health Preferred Network - \$250 person / \$750 family Tier Two and Three UHC Choice Plus Network & Out-of-Network - \$500 person / \$1,500 family</p> <p>Does not apply to Copayments and services listed below as "No Charge" unless noted otherwise in Limitations & Exceptions column.</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Preventive care services are covered before you meet your deductible.</p>	<p>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/</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>Yes. \$4,000 person / \$12,000 family</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Penalties, premiums, balance billing charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.umar.com or call 1-877-217-7800 for a list of network providers. If you are unsure which network list to select, please call 1-877-217-7800. IMPORTANT: All Mayo providers and Banner Health facilities and hospitals are considered out-of-network, except as follows:</p> <ul style="list-style-type: none"> • 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 Tier 2 network benefits level. • Transplant services provided by OptumHealth 	<p>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.</p>

Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .
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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 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 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 provider will be considered out-of-network and 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	Services rendered by any Mayo provider or 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)	
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	40% Coinsurance	Not Covered	Services rendered by any Mayo provider or 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. More information about prescription drug coverage is available at www.umar.com .	Generic drugs (Tier 1)	\$5 Copay per prescription (St. Joseph's McAuley Pharmacy / AU Cancer Center St. Joseph's Outpatient Pharmacy); \$14 Copay per prescription (retail); \$20 Copay per prescription (mail order)		Not Covered	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 Deductible and Out-of-pocket limit applies
	Preferred brand drugs (Tier 2)	\$20 Copay per prescription (St. Joseph's McAuley Pharmacy/AU Cancer Center St. Joseph's Outpatient Pharmacy); \$50 Copay per prescription (retail); \$70 Copay per prescription (mail order)			
	Non-preferred brand drugs (Tier 3)	\$40 Copay per prescription (St. Joseph's McAuley Pharmacy/AU Cancer Center St. Joseph's Outpatient Pharmacy); \$90 Copay per prescription (retail); \$140 Copay per prescription (mail order)			
	Specialty drugs (Tier 4)	25% Copay with a Minimum of \$25 up to a Maximum of \$100 per prescription			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	40% Coinsurance	Not Covered	Services rendered by any Mayo provider or 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 provider or 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 need immediate medical attention	Emergency room care	\$250 Copay per visit	\$250 Copay per visit	\$250 Copay per visit	Copay may be waived if admitted; Non-emergency services are not covered. Emergency room service claims for non-emergency services will be denied
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	10% Coinsurance	Deductible Waived
	Urgent care	\$30 Copay per visit	\$75 Copay per visit	Not Covered	Mayo and Banner Health 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 provider or 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 a Mayo provider will be considered out-of-network and not covered.
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	\$20 Copay Per Office Visit 10% Coinsurance other outpatient services	\$40 Copay Per Office Visit 40% 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 network benefit level.
	Inpatient services	10% Coinsurance	40% 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 network benefit level.

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 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 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	
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 by \$250 of the total cost of the service. . Any services rendered by a Mayo provider is considered out-of-network and not covered
	Rehabilitation services	\$20 Copay per visit;	40% Coinsurance	Not covered	Any services rendered by a Mayo provider or 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 by \$250 of the total cost of the service.

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)	
	Durable medical equipment	10% Coinsurance Deductible Waived	10% Coinsurance	Not Covered	Prior authorization is required for DME in excess of \$500 for rentals or \$1,500 for purchases
	Hospice service	10% Coinsurance	40% Coinsurance	Not Covered	Any services rendered by a Mayo provider or 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 Chiropractic care Hearing aids Non-emergency care when traveling outside the U.S.
 Bariatric surgery Limitations may apply. Private Duty Nursing (Outpatient care)

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: U.S. Department of Labor's 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? 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](#).

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, kwijigo holne' 1-916-631-3051

—————*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](#) \$250
- [Specialist copayment](#) \$30
- 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$30
Coinsurance	\$755

What isn't covered

Limits or exclusions	\$0
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The total Peg would pay is	\$1035
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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 copayment](#) \$30
- 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	\$1,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$0
Copayments	\$480
Coinsurance	\$100

What isn't covered

Limits or exclusions	\$0
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The total Joe would pay is	\$580
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Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$0
- Hospital (facility) [copay](#) \$250
- Other [\(therapy\) copay](#) \$20

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	\$2,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$0
Copayments	\$450
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is	\$450
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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.