UMR: DIGNITY HEALTH: 7670-00-412517 001 - DHMP Nevada EPO

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 EPO) 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, For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.umr.com or call 1-866-868-2701. 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.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. 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.
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?	Yes. $6,000 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.
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.	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 you need a referral to see a specialist?	No.	

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
		Your Cost if you use a Tier 1 Provider	Your cost if you use a Tier 2 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	$5 Copay per visit	$40 Copayment	Not Covered	Deductible Waived
	Specialist visit	$20 Copay per visit	$80 Copayment	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) and Imaging (CT/PET scans, MRIs)	X-ray: Outpatient Radiology Center or Provider's Office: $5 copayment; Dignity Health Hospital: $25 copayment. Imaging: Outpatient Radiology Center: $25 copayment; Dignity Health Hospital: $75 copayment. PET Scan: Must be performed at a Dignity Health Hospital: $100 copayment.	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 Imaging (CT/PET scan, MRIs)
	Diagnostic Lab	Outpatient Lab Center or Provider's Office: $5 copayment	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
		Your Cost if you use a Tier 1 Provider	Your cost if you use a Tier 2 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	$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. Specialty Pharmacy must be used for Specialty drugs.
	Preferred brand drugs	$30 Copay per prescription (retail) $60 Copay per prescription (mail order)		Not Covered	
	Non-preferred brand drugs	$50 Copay per prescription (retail) $100 Copay per prescription (mail order)		Not Covered	
	Specialty drugs	Generic: $7 Copay per prescription Preferred brand: $30 Copay per prescription Non-preferred brand: $50 Copay per prescription		Not Covered	
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 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	Prior authorization is required.
	Physician/surgeon fees	$50 Copay per visit surgeon	50% Coinsurance	Not Covered	————none————
If you need immediate medical attention	Emergency room care	$75 Copay per visit True ER	$75 Copay per visit True ER	$75 Copay per visit 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 per visit	$20 Copay per visit	Not Covered	Deductible Waived

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your Cost if you use a Tier 1 Provider	Your cost if you use a Tier 2 Provider	Out-of-Network Provider (You will pay the most)	
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 fees	No charge	Physician: No charge per admission; Surgeon: 50% Coinsurance	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services: Mental/Behavioral health and Substance use disorder	$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.
	Inpatient services: Mental/Behavioral health and Substance use disorder	$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.
If you are pregnant	Office visits	No charge	No charge Prenatal; 20% Coinsurance Postnatal	Not Covered	Deductible Waived Prenatal
	Childbirth/delivery professional services	100%			
	Childbirth/delivery facility services	$100 Copay per admission	Not Covered, unless services not available in Tier 1 or in an	Not Covered	Deductible Waived

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your Cost if you use a Tier 1 Provider	Your cost if you use a Tier 2 Provider	Out-of-Network Provider (You will pay the most)	
			emergency. If services not available in Tier 1, then services covered at Tier 1 benefit level		
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 and combined with Habilitation services Prior authorization is required.
	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, then No charge	20% Coinsurance	Not Covered	Prior authorization is required for DME in excess of $500.
	Hospice services	$100 Copay per admission Inpatient; No charge Outpatient	20% Coinsurance	Not covered	————none————
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 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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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 Standards? 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, 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.

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

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 *copay*	$20
Hospital (facility) *copay*	$100
Other *[cost sharing]*	%0

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	$7500

In this example, Peg would pay:

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

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 copay	$20
Hospital (outpatient lab) *copay*	$5
Other *[pharmacy] copay*	$30

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	$2000

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$450
Coinsurance	$0
What isn't covered	
Limits or exclusions	$
The total Joe would pay is	$450

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

The plan's overall deductible	$0
Specialist *copay*	$20
Hospital (facility) *copay*	$75
Other *(therapy) copay*	$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	$5000

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$175
Coinsurance	$0
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	$175

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