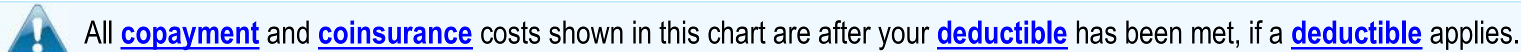
Board of Trustees of the Rocky Mountain UFCW Unions & Employers Health Benefit Plan: Plan B UnitedHealthcare/UMR: Premium Care Provider Network

Coverage for: Individual, Individual + Family | **Plan Type:** PPO

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, call 1-800-527-1647. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$600**/person, **$1,800**/family. (When three family members each meet their individual deductible, the family deductible is met.)	Generally, you must pay all of 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 three family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Network preventive services, network office visits and prescription drugs 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 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.
Are there other deductibles for specific services?	**50**/person dental deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services..
What is the out-of-pocket limit for this plan?	In-network: coinsurance limit: **$3,000**/person, **$5,000**/family; out-of-pocket limit: **$6,350**/person, **$12,700**/family. Out-of-network: coinsurance limit: **$9,000**/person, **unlimited**/family; out-of-pocket limit: **unlimited**.	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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Coinsurance limit: Premium, balance-billed charges, copays, plan deductibles, prescription drugs, dental and vision	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
	expenses, preauthorization penalties, and health care this plan doesn't cover. Out-of-pocket limit: Premium, balance-billed charges, dental and vision expenses, and health care this plan doesn't cover.	
Will you pay less if you use a network provider?	Yes. See www.umr.com or call 1-800-826-9781 for a list of network providers. For mental health/substance abuse treatment providers, call Mines & Associates at 1-800-873-7138.	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 (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 **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 Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions*, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/office visit and 25% coinsurance/procedures during office visit; deductible does not apply to office visit	45% coinsurance	Network telehealth visit: $30 copay/visit.
	Specialist visit	Premium Care Specialist: $40 copay/visit; Non-Premium Care Specialist: $50 copay/ visit; 25% coinsurance/ procedures during office visit; deductible does not apply to office visit.	45% coinsurance	None.
	Preventive care/screening/ immunization	No charge; deductible does not apply	45% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Out-of-network limited to mammograms, pap smears, PSA testing and colonoscopies.

* For more information about limitations and exceptions, see the plan or policy document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions*, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	45% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	$75 copay/day, plus 25% coinsurance	$75 copay/day, plus 45% coinsurance	Preauthorization required; $100 benefit reduction if failure to preauthorize.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** will be available at www.express-scripts.com	Generic drugs	34-day supply: $5 copay; 90-day supply: $10 copay. Deductible does not apply.	Not covered	If you receive a brand name drug when a generic drug is available, you will pay the generic drug copay plus the difference in cost between the generic and brand name drug. Some exceptions apply. Coverage is limited up to a 34-day supply (retail and specialty drugs) or a 90-day supply if prescribed by your Physician; certain drugs may be subject to preauthorization or step therapy; preauthorization is required for specialty drugs.
	Preferred brand drugs	34-day supply: 20% coinsurance up to $50/prescription; 90-day supply 20% coinsurance up to $100/prescription. Deductible does not apply.	Not covered	
	Non-preferred brand drugs	34-day supply : 30% coinsurance up to $75/prescription; 90-day supply: 30% coinsurance up to $150/prescription. Deductible does not apply.	Not covered	
	Specialty drugs	20% coinsurance up to $100/prescription. Deductible does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	45% coinsurance	Preauthorization is required; $100 penalty for failure to preauthorize.
	Physician/surgeon fees	25% coinsurance	45% coinsurance	
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	None.
	Emergency medical transportation	25% coinsurance	25% coinsurance	
	Urgent care	25% coinsurance	25% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	45% coinsurance	Preauthorization is required. $100 penalty for failure to preauthorize.

* For more information about limitations and exceptions, see the plan or policy document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions*, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	25% coinsurance	45% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/office visit and 25% coinsurance for other outpatient services; deductible does not apply to office visit	45% coinsurance	None.
	Inpatient services	25% coinsurance	45% coinsurance	Preauthorization is required. $100 penalty for failure to preauthorize.
If you are pregnant	Office visits	Applicable office visit copay/visit; 25% coinsurance/procedures during office visit; deductible does not apply to office visit	45% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	25% coinsurance	45% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	45% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	25% coinsurance	Coverage is limited to 40 days/year; preauthorization required; $100 benefit reduction if failure to preauthorize.
	Rehabilitation services	25% coinsurance; 50% coinsurance/Speech Pathologist (non-Hospital)	45% coinsurance; 50% coinsurance/Speech Pathologist (non-Hospital)	Coverage for Speech Pathologist limited to 50 days/year for loss of function due to illness or injury.
	Habilitation services	Not covered	Not covered	Coverage is excluded.
	Skilled nursing care	25% coinsurance	45% coinsurance	Preauthorization required; $100 benefit reduction if failure to preauthorize.
	Durable medical equipment	25% coinsurance	45% coinsurance	Preauthorization required; $100 benefit reduction if failure to preauthorize.
	Hospice services	25% coinsurance	25% coinsurance	None.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	None.
	Children's glasses	All charges in excess of two-calendar year limit	All charges in excess of two-calendar year period	Coverage limited to following two calendar year limits: $240 (single), $260 (bifocal), $290 (trifocal) for frames and lenses.

* For more information about limitations and exceptions, see the plan or policy document.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions*, & Other Important Information
	Children's dental check-up	No charge; dental deductible does not apply	20% coinsurance; dental deductible does not apply	Coverage limited to 2 visits/12 month period.

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.)

- Acupuncture
- Cosmetic surgery, except to repair damage from an accident, that is incidental to or follows surgery that results from trauma or infection, to enable you to eat, or as required by law
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Bariatric surgery (specific criteria must be met)
- Chiropractic care (15 visits/year maximum)
- Dental care (Adult) $1,500/year
- Routine eye care (Adult), up to two-calendar year limit, including exam

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 the Department of Labor's Employee Benefits Security Administration is 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: the Plan at 1-800-527-1647, 1-800-826-9781 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit..

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.

* For more information about limitations and exceptions, see the plan or policy document.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-350-6774.

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

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** **$600**
- **Specialist copayments** **$40**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$190
Coinsurance	$2,950
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,800**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$600**
- **Specialist copayments** **$40**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copayments	$440
Coinsurance	$780
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,360**

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

- **The plan's overall deductible** **$600**
- **Specialist copayments** **$40**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$280
Coinsurance	$420
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

44208250v4

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