Rocky Mountain UFCW Unions & Employers

HEALTH BENEFIT PLAN

2017 Newly Eligible Enrollment Guide

Your Benefits Your Options Your Choice

EXPRESS LANE to Good Health

Rocky Mountain UFCW Unions & Employers Health Benefit Plan

Healthcare Management Program

2017Newly Eligible Enrollment Guide

Welcome to the Rocky Mountain UFCW Unions & Employers Health Benefit Plan! As an eligible participant in the Health Benefit Plan (the Plan), this is your opportunity to enroll yourself and any eligible dependents for Plan coverage for the balance of 2017.

Enroll Within 90 Days

When you become eligible for coverage, you must enroll and authorize payroll deductions (if required under your collective bargaining agreement) within 90 days of the date shown on your enrollment materials to be covered under the Plan in 2017. Any required payroll deductions are required as of the first payday of the month in which you are initially eligible for benefits. Your coverage will also be effective as of your initial eligibility for coverage as long as you enroll for coverage within 90 days of the date shown on your enrollment materials. If your spouse is eligible for coverage under this Plan as well as his/her employer's plan and elects not to enroll in his/her employer's plan, you are required to make an additional weekly contribution for his/her coverage under this Plan. If you do not enroll when you are first eligible, you cannot enroll until the next open enrollment period, subject to your Special Enrollment Rights (see page 10 of this Guide).

Important Reminder

You must actively enroll within 90 days of the date shown on your enrollment materials to have coverage in 2017. If you do not enroll in this period, you will not have coverage under the Plan in 2017, subject to your Special Enrollment Rights (see page 10 of this Guide). Your next opportunity to enroll for coverage will be during open enrollment in the fall of 2017 for coverage effective January 1, 2018, subject to your Special Enrollment Rights (see page 10 of this Guide).

ABOUT THIS GUIDE

This 2017 *Newly Eligible Enrollment Guide* is designed to help you make informed decisions about your benefits and to help you complete the enrollment process.

Please take the time to review this 2017 *Newly Eligible Enrollment Guide* carefully. It is up to you to understand your benefits and how they work, and to complete your enrollment for 2017 within 90 days of the date shown on your enrollment materials.

If you have questions regarding the Plan, the enrollment process, or enrolling online, contact the Plan Office at 303-430-9334 or 800-527-1647.

SAVE $$$$: Whether you elect coverage in the Cigna PPO Plan or the Kaiser Permanente HMO Plan, you have to complete a Health Assessment generally within 90 days of the completion of your enrollment to be eligible for a monthly co-premium reduction in 2017.
See page 4 for more information.

The code to the left will take you directly to the enrollment website: www.zenith-american.com. If you have a smartphone with a camera, you can scan this code and it will take you to our website. You will need to download a free QR code scanner app first.

YOUR 2017 BENEFITS

The Plan offers medical, prescription drug, dental, vision, weekly disability, life, and accidental death and dismemberment (AD&D) coverage. When you are eligible, you must enroll to receive Plan coverage. If you do not enroll when you are initially eligible, you will not be covered under any of the Plan's benefits, unless you enroll during Open Enrollment for coverage effective the following January 1.

The Plan offers two medical programs for you to choose from:

- **Cigna PPO Medical Plan.** The Cigna PPO Plan provides medical benefits through the Cigna HealthCare Open Access Plan (OAP), a preferred provider organization (PPO), that uses the Cigna Open Access Plus network of providers. Each time you receive care, you have the choice of using a network or non-network provider. Cigna also administers the Plan's prescription drug benefits.
- **Kaiser Permanente HMO Plan.** The Kaiser Permanente HMO Plan provides medical and prescription drug benefits through the Kaiser Permanente Health Maintenance Organization (HMO), Group 8600/Plan 620. In general, you must use a Kaiser Permanente HMO provider when you receive care, except in a true medical emergency when non-HMO provider care may be covered. You are only eligible to enroll in the Kaiser Permanente HMO Plan if you live or work in the Kaiser Permanente HMO service area. When enrolling, you must provide a street address; P.O boxes are not accepted. If you just work in the new service area but do not live there and wish to enroll in the Kaiser Permanente HMO Plan, please contact the Plan Office for an enrollment form; your enrollment is subject to Kaiser's review and approval. To find out if Kaiser is available where you live, go to www.kp.org or call 800-632-9700 or 303-338-3800.

If you elect coverage for yourself under either the Cigna PPO Plan or the Kaiser Permanente HMO Plan, you are eligible for vision, dental (provided you have met the eligibility requirements), weekly disability, life, and AD&D coverage.

If you decline medical, prescription drug, vision and dental coverage, you will also *NOT* be enrolled for weekly disability, life or AD&D coverage.

How The Plan Works

While the Plan is sponsored and administered by the Board of Trustees, the Trustees have delegated administrative responsibilities to other individuals or organizations. The chart below provides the contact information for the various organizations that provide services under the Plan.

If You Have a Question or Need Information About:	Contact:	Phone Numbers:	Website:
Enrollment, Eligibility, Updating Personal Information, Weekly Disability Benefits, Vision Benefits and General Participant Questions	Plan Office (Zenith American Solutions) *Physical Address* 5511 West 56th Avenue, Ste. 250 Arvada, CO 80002 *Mailing Address* P.O. Box 447 Arvada, CO 80001-0447	303-430-9334 *or* 800-527-1647	www.zenith-american.com
Medical Network Providers, Utilization Review, and Prescription Drug Benefits			
PPO	Cigna	800 Cigna24 (800-244-6224)	www.mycigna.com
HMO	Kaiser Permanente (Group 8600/ Plan 620)	800-632-9700 *or* 303-338-3800	www.kp.org
Mental Health and Substance Abuse Treatment PPO Network and Utilization Review Provider	Mines & Associates	800-873-7138 *or* 303-832-1068	www.minesandassociates.com
Dental Benefits	Delta Dental	800-610-0201 *or* 303-741-9305	www.deltadentalco.com
Life or AD&D Insurance Benefits	Metropolitan Life Insurance Company (MetLife) Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100	800-638-6420	www.metlife.com

IMPORTANT INFORMATION

What's In Your Enrollment Package

Your enrollment package includes the following:

- A benefits summary showing the benefits you are eligible to receive;
- A Summary Plan Description (SPD);
- An enrollment form;
- A Notice of Privacy Practices;
- A Notice of Prescription Drug Creditable Coverage;
- A HIPAA Authorization for Release of Health Information;
- A Section 1557 Non-Discrimination Notice;
- An EEOC Wellness Program Notice; and
- A Summary of Benefits and Coverage ("SBC") which is required to be provided to you by federal law. The SBC describes some of the benefits provided by the Plan in general terms, but does not provide all of the rules under which the Plan operates. Full details of the Plan are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording in the summary and the documents that establish the Plan provisions, the documents will govern.

Health Assessment Reminder

Whether you elect coverage in the Cigna PPO Plan or the Kaiser Permanente HMO Plan, you have to fully complete a Health Assessment to be eligible for a monthly co-premium reduction in 2017. Participants who elect coverage in the Cigna PPO Plan have the option of completing a Cigna Health Assessment, and those electing coverage in the Kaiser Permanente HMO Plan have the option of completing a Kaiser Total Health Assessment.

If you don't complete a Health Assessment generally within 90 days of the completion of your enrollment, you'll pay the full co-premium. See page 4 for more information.

Take Advantage of Cigna High Performance Specialists

If you elect to have Cigna PPO Plan coverage, you can take advantage of Cigna's High Performance Specialists. High Performance Specialists are doctors in the Cigna Care Network (CCN) who meet or exceed specific quality and cost efficiency standards in one of 19 specialties. By knowing which specialists excel in these areas, you can more confidently choose a doctor who is right for you.

Under the Plan, **you will pay lower out-of-pocket costs when you choose a Cigna High Performance Specialist** for covered services. This means that **your co-payments will be lower** with a Cigna High Performance Specialist than with a specialist in the Cigna network who is not a Cigna High Performance Specialist.

You can find out which specialists are Cigna High Performance Specialists at www.mycigna.com or by calling Cigna.

Enrolling A Dependent For Plan Coverage?

If you are covering dependents under the Plan, you are required to submit documentation to the Plan Office. If you enroll a dependent for coverage, the Plan Office will send you a letter that explains what you need to do and what documents you will need to submit to obtain coverage for a dependent. Only your dependents that meet the Plan's definition of eligible dependents may be enrolled.

Kaiser's definition of Dependent differs for a stepchild or a child under legal guardianship. Kaiser also offers coverage to civil union partners. Call the Plan Office for information.

You must enroll a newborn child (or a newly acquired child) within 60 days of the birth (or acquisition). Do not wait until you have received a Social Security Number or a birth certificate for a newborn dependent. You should enroll a newborn dependent as soon as possible. If you have applied for a Social Security Number for a newborn, but have not yet received it, please contact the Plan Office. If you do not enroll a newborn child (or newly acquired child) within 60 days, your next opportunity to enroll that child will be the next open enrollment in the fall of 2017 for coverage effective January 1, 2018.

Initial Eligibility for Plans A, B, and C (Not Including Dental Benefits)

The Plan's initial eligibility requirements for Plans A, B, and C (except Dental Benefits, which are described below) are as follows:

- **Plan A:** Generally, you and your Dependents are eligible to enroll for Plan A coverage as of the first day of the month after you have been eligible for Plan B for 36 months, or the date set forth in your collective bargaining agreement, if earlier. Courtesy Clerks are not eligible for Plan A.
- **Plan B:**
  - ***Full-Time Non-Courtesy Clerks:*** You and your Dependents are generally eligible to enroll for Plan B coverage the earlier of the first of the month following the date that is 30 days after 300 hours of employment, or the date set forth under the current collective bargaining agreement.
  - ***Part-Time Non-Courtesy Clerks:*** You and your Dependents are generally eligible to enroll for Plan B coverage after you have been eligible for Plan C for 36 months, or the date set forth in your collective bargaining agreement, if earlier.
  - ***Courtesy Clerks:*** You and your Dependents are generally eligible to enroll for Plan B coverage after you have been eligible for Plan C for 36 months, or the date set forth in your collective bargaining agreement, if earlier.
- Plan C:
  - **Part-Time Non-Courtesy Clerks:** You are generally eligible to enroll for Plan C coverage as of the first day of the month after working an average of 20 hours a week during the 12 months after your date of hire. If you average less than 20 hours a week during the 12 months after your date of hire, then you generally become eligible to enroll for Plan C coverage on the first of the month after you work the minimum required hours (as provided by your collective bargaining agreement). Your initial eligibility date may be different depending on the the rules set forth in your collective bargaining agreement. Your Dependents are eligible when you become eligible, and you may enroll them for coverage.
  - **Courtesy Clerks:** You and your dependents are generally eligible to enroll for Plan C coverage as of the date set forth in your collective bargaining agreement or, if earlier:
    - **For the first 36 months of employment:** the first day of the month after the date you work an average of 30 hours per week during the 12 months following your date of hire or in a subsequent 12-month period following your anniversary date;
    - **After 36 months of employment:** the first of the month after the date you work an average of 20 hours per week for a 12-month period; if you average less than 20 hours of work per week, then you become eligible on the date set forth in your collective bargaining agreement or, if earlier, on the first of the month after you work the minimum required hours (as provided by your collective bargaining agreement).

Initial Eligibility Requirements for Dental Benefits

You and your Dependents are eligible for Dental Benefits as follows:

- **Plan A:** You and your Dependents are eligible for Plan A Dental Benefits when you are eligible for and enrolled in Plan A medical coverage provided you have completed 15 full months of continuous employment.
- **Plan B:**
  - ***Full-Time Non-Courtesy Clerks:*** You and your Dependents are eligible for Plan B Dental Benefits as of the first day of the month following 15 full months of continuous employment, provided you are also eligible for and enrolled in Plan B medical coverage.
  - ***Part-Time Non-Courtesy Clerks and Courtesy Clerks:*** You and your Dependents are eligible for Plan B Dental Benefits when you are eligible for and enrolled in Plan B medical coverage.
- **Plan C:**
  - ***Part-Time Non-Courtesy Clerks:*** You and your Dependents are eligible for Plan C Dental Benefits as of the first day of the month after 15 full months of continuous employment, provided you are also eligible for and enrolled in Plan C medical coverage.
  - ***Courtesy Clerks:*** You are eligible for Plan C Dental Benefits as of the first day of the month after 36 full months of continuous employment, provided you are also eligible for and enrolled in Plan C medical coverage.

Dental Benefits include four basic categories:

- Diagnostic, preventive, and adjunctive services (available to all participants once you have satisfied the Plan's dental waiting period);
- Basic and major services (available to **Plan A** participants only);
- Temporomandibular (TMJ) services (available to **Plan A** participants only); and
- Orthodontia (available to **Plan A** participants only).

REMEMBER TO COMPLETE YOUR ANNUAL HEALTH ASSESSMENT AND REDUCE YOUR MONTHLY MEDICAL CO-PREMIUMS FOR 2017

Active participants and spouses with coverage through the Cigna PPO Plan or the Kaiser Permanente HMO Plan in Plan A, B or C can complete an annual Health Assessment—and earn a reduction in monthly medical coverage co-premiums.

If either you or your enrolled spouse completes a Health Assessment generally within 90 days of the completion of your enrollment, you will receive a $5 monthly co-premium reduction in 2017. If you both complete Health Assessments generally within 90 days of the completion of your enrollment, you will receive a $10 monthly co-premium reduction in 2017.

The Health Assessment is an important first step in understanding your health status. After completing the Health Assessment (which takes about 10 to15 minutes), you will be able to print out a report of your results which you can use to discuss with your doctor. You'll also get suggestions for improving your health.

Note: You can also complete a paper assessment, though it will take longer to get your results. Call the Plan Office for more information.

Your responses to the Health Assessment are strictly confidential. The Plan, your Employer and your Union will not have access to your input or results.

How do I take a Health Assessment?

Cigna Health Assessment: Go to www.mycigna.com or scan the QR code to the right, log in or register, and then select "**Take My Health Assessment**."

Kaiser Permanente Total Health Assessment: Go to www.kp.org or scan the QR code to the right, log in or register, click on "Health & wellness," then "Programs & classes," and then **"Total Health Assessment."**

Please call the Plan Office to verify your eligibility and to find out more about completing your Health Assessment and reducing your monthly co-premiums.

If you don't complete a Health Assessment generally within 90 days of the completion of your enrollment, you'll pay the full co-premium in 2017.

Partial completion of the Health Assessment will not result in the co-premium reduction.

HOW THE MEDICAL PROGRAMS WORK

Plan Feature	Cigna PPO Medical Plan	Kaiser Permanente HMO Plan
Providers	You may go to any health care provider. However, when you use Non-Network Providers, you pay a higher percentage and your Coinsurance Limit is higher and you are not subject to an Out-of-Pocket Limit.	You must use HMO providers and have your care coordinated by your Primary Care Physician (PCP), which you select for each covered individual. Self-referral is available for diagnostic visits with a specialist. Only emergency care is covered for non-HMO providers.
Network	Cigna HealthCare Open Access Plan (OAP), a preferred provider organization (PPO). To locate a Network Provider, contact Cigna directly by: • Visiting www.mycigna.com; or • Calling 800-244-6224. Remember to look for providers who are in the Cigna High Performance Specialist Network (also called the Cigna Care Network).	Kaiser Foundation Health Plan of Colorado Health Maintenance Organization (HMO). To locate an HMO provider, contact Kaiser Permanente directly by: • Visiting www.kp.org; or • Calling 303-338-3800 or 800-632-9700 (TTY users call 800-521-4874). To contact the Kaiser Permanente Clinical Pharmacy, call 303-338-4503 or 800-632-9700 (TTY users call 800-521-4874).
Deductible	You must meet your Deductible before the Plan pays for most covered services. The Deductible applies to all Covered Expenses except as noted in the attached Benefit Summary. For example, the deductible does not apply to Network Physician office visits or prescription drug Co-payments.	You must meet your Deductible before the Plan pays for most covered services, including inpatient hospital, outpatient surgery, therapeutic X-ray, MRI, CAT, PET, hospice, and skilled nursing facility care.
Coinsurance	Once you or your family (if applicable) meet the annual Deductible, the Plan pays a percentage of Covered Expenses and you pay the rest. The Coinsurance percentage paid varies, depending on whether you use Network or Non-Network Providers. You pay Coinsurance amounts until you reach the Coinsurance Limit. The Coinsurance Limit amount depends on if you use Network or Non-Network Providers, and is a different amount per person and per family.	Once you or your family (if applicable) meet the annual Deductible, the Plan pays a percentage of Covered Expenses and you pay the rest. The Coinsurance percentage paid varies, depending on the covered service provided.
Co-payments	When you or a family member (if applicable) go to a Network Physician's office, you pay a separate Co-payment for each office visit. In addition, advanced radiology procedures and prescription drugs are subject to Co-payments. Once you pay your Co-payments, the Plan pays a percentage of the remaining Covered Expenses. You are responsible for paying these Co-payments even if you have met your Deductible or Coinsurance Limit. Your Co-payments do not apply toward meeting your annual Deductible. Your Office Visit, Advanced Radiology and prescription drug Co-payments do apply towards meeting the Out-of-Pocket Limit.	For certain services, you or a family member (if applicable) pay separate Co-payments before the Plan pays any benefits. After the Co-payments, the Plan pays a percentage of remaining Covered Expenses. You or a family member (if applicable) are responsible for paying these Co-payments even if you have met your Deductible and Out-of-Pocket Limit.
Out-of-Pocket Limit	Once you meet your Deductible and your other Covered Network Expenses reach the Out-of-Pocket Limit, the Plan pays 100% of most Covered Network Expenses you incur for the rest of the year. Once you or your family (if you elect family coverage) meets the per person or per family Network Out-of-Pocket Limit, the Plan pays 100% of most Covered Network Provider Expenses for you and your Eligible Dependents. There is no per person or per family maximum for Non-Network Provider Covered Expenses. Please note that Network amounts you pay toward meeting your annual Deductible, Co-payments and Coinsurance amounts (including prescription drug Co-payments and expenses applied to the Coinsurance Limit) do apply toward meeting your Out-of-Pocket Limit. **Only Network expenses apply toward meeting the Out-of-Pocket Limit.**	Once you meet your Deductible and your other Covered Expenses reach the Out-of-Pocket Limit, the Plan pays 100% of most Covered Expenses you incur for the rest of the year. Once your family (if you elect family coverage) meets the family Out-of-Pocket Limit, the Plan pays 100% of most Covered Expenses for you and your Eligible Dependents. Please note that amounts you pay toward meeting your annual Deductible and Co-payments do apply toward meeting your Out-of-Pocket Limits.

WEEKLY SELF-PAYMENT DEDUCTIONS FOR COVERAGE

To be covered under the Plan, weekly self-payment deductions are required for coverage. Self-payment rates, including the additional working spouse self-payment rate, are subject to change. By completing the enrollment process, you are authorizing your agreement to the weekly self-payment deductions from your paycheck. The weekly self-payment deduction depends on the level of coverage you elect, as follows:

Coverage Level	Weekly Self-Payment Deduction
Employee-Only	$7.50 per week
Employee and Dependent Child(ren) or Employee and Spouse	$15.00 per week
Family (Employee, Spouse, and Dependent Child(ren))	$23.00 per week

During periods when you are eligible for benefits under the Plan and you are receiving wages from your employer, your self-payment is deducted from your weekly paycheck. During periods when you are not receiving wages from your employer, but you remain eligible for coverage under the Plan due to your employer's continuous contributions to the Plan on your behalf, the required self-payments will be deducted from your paycheck when you return to work. This applies, for example, when you return to work from a qualified leave of absence.

You are authorizing your agreement to the weekly self-payment deductions from your paycheck by completing the enrollment process.

Additional Working Spouse Self-Payment

If you enroll your spouse and he/she is eligible for coverage under his/her employer-sponsored plan, but elects not to enroll in that plan, an additional $23.08 weekly self-payment deduction is currently required. To avoid this additional weekly self-payment deduction, your spouse must be enrolled in his/her employer-sponsored plan. Otherwise, your weekly self-payment deduction will include this additional $23.08. This amount will continue to be deducted until your spouse enrolls in the employer-sponsored plan available to him/her or your spouse is no longer working or the employer is no longer providing coverage.

If you enroll your spouse and/or dependent child(ren) in the Plan, they are eligible for medical, prescription drug, and vision benefits (and dental benefits if you have met the eligibility requirements for dental benefits).

If Both You and Your Spouse Are Employees

If you and your spouse are both eligible for coverage as employees under the Plan, the working spouse rule previously described does not apply to you and your spouse. If both you and your spouse want weekly disability, life, and AD&D coverage, you may both want to elect coverage, as follows:

- If you have no dependent children—You should each elect Employee-Only coverage (a $7.50 per week self-payment deduction per person).
- If you have dependent children—One of you should elect Employee-Only coverage (a $7.50 per week self-payment deduction) and the other should elect Employee and Dependent Child(ren) coverage (a $15.00 per week self-payment deduction).

To enroll your spouse in the Plan for 2017, follow the enrollment instructions listed in this *Guide*.

Please note if your spouse elects coverage as a dependent (and not as an employee), your spouse will not be eligible for weekly disability, life and AD&D coverage.

ENROLLMENT 2017

You can enroll online through a web-based enrollment system administered by Zenith American Solutions, by telephone with a live person helping you through the process, or by completing and submitting the enclosed enrollment form. Whichever way you choose, you and your family will be able to review your benefits for 2017, make your benefits decisions together, and then enroll. (See below for enrollment instructions.) You must enroll within 90 days of the date shown on your enrollment materials to be covered in 2017, subject to your Special Enrollment Rights.

Waiving Coverage for 2017

If you wish to waive coverage for 2017, we still ask you to complete the enrollment process online, by telephone or with the enclosed paper enrollment form.

If you do not enroll in the proper time period and decline coverage, you (and any dependents) will not be enrolled for medical, prescription drug, vision and dental coverage, and you will also not be enrolled for weekly disability, life insurance, or AD&D coverage.

How to Enroll Three Easy Options

A. Online Enrollment Instructions

The online enrollment process makes enrolling in and managing your benefits fast and easy. The system enables you to:

- Enter your personal and dependent information, including eligibility for other coverage.
- Enroll for benefits for 2017, including selecting the level of coverage that is right for you.
- Enroll your eligible dependents.
- Select your beneficiary (or beneficiaries) for your life and AD&D benefits.

Are you enrolling dependents for Plan coverage?

The Plan Office will contact you to request any necessary documentation for your dependents.

When you enroll online, enrollment confirmation is automatic. You simply indicate how you would like to receive your confirmation statement during the online enrollment process.

The web-based enrollment system is available 24 hours a day.

If you are a first-time computer user, novice internet user, or you would just like some help enrolling online, you can contact the Plan Office at 303-430-9334 or 800-527-1647 for assistance.

Just follow the steps listed below to get started.

1. Find a Computer with a Connection to the internet

You need a computer with a connection to the internet to complete your enrollment online. If you do not have access to an internet-connected computer at home, several alternatives are available:

- **Plan Office:** Computers are available for enrollment at the Plan Office (Zenith American Solutions). Office hours are from 8:30 a.m. to 4:30 p.m., Monday through Friday. The Plan Office address is: Zenith American Solutions, 5511 West 56th Avenue, Suite 250, Arvada, CO 80002. To contact the Plan Office for more information, call 303-430-9334 or 800-527-1647.
- **UFCW Local 7 Office (Denver):** Assistance will be available at the UFCW Local 7 office in Denver. The office is located at 7760 West 38th Avenue, Suite 400, Wheat Ridge, Colorado 80033. To contact the office for more information, call 303-425-0897 or 800-854-7054.
- **Public Library:** Most public libraries provide free access to computers with internet connections. Check with your local library for its hours and information on using its computers.

2. Go to the Plan's Enrollment Website

Once you have access to the internet, go to **www.zenith-american.com** (type this into the internet browser bar or scan the code to the right). The website is available 24 hours a day, seven days a week.

3. Log In to the Site

If You Have Used the Online System Before

To log in to the site, you will need to enter your Username and Password. If you've logged in before and have forgotten your Username or Password, click on "Forgot your username or password?" to set a new Username and Password.

If You Have NOT Used the Online System Before

If you have never used the system before:

- In the Account Type box on the right side of the page, select "Participant" as your Account Type.
- Your Username is your last name (e.g., if your name is David Garcia, simply enter GARCIA into the Username field).
- Your Password is either your Social Security Number or your alternate ID number provided by the Plan. When entering your Password, do not use dashes; simply enter the nine numbers.

In some cases, your Username may be a little more complicated to figure out. For example, if the Plan Office's records for you include a "Jr." or "II" after your last name, you will need to include those letters within your Username. For example, if your name is "David Garcia Jr.", your Username is GARCIAJR. You'll see some more examples in the table on the next page.

Name (As it appears on the address label of your enrollment kit.)	**Username**
John Andrews, Jr	**ANDREWSJR** (Include JR after ANDREWS with no space)
Pat Davidson III	**DAVIDSONIII** (Include III after DAVIDSON with no space)
Robert Maguire, Sr	**MAGUIRESR** (Include SR after MAGUIRE with no space)
Patricia Van Buren	**VANBUREN** (Type VANBUREN in as one word)
Paul O'Malley	**O'MALLEY** (Include apostrophe with no space)
Jane Smith-Jones	**SMITH-JONES** (Include hyphen with no space)

Personalize Your Login Information

To protect the confidentiality of your personal information, you will be asked to change your Password the first time you log in to the site.

Be sure to choose a Password that you can remember. Your Username should already be filled in. Fill in the remaining information on this screen; be sure to include an e-mail address if you have one and would like to receive electronic confirmations or notifications. Once you have entered all necessary information, click the Modify button.

4. Enter Your 2017 Enrollment Elections

Once you log in to the site, follow the step-by-step instructions on the enrollment site.

5. After Enrolling

Once you enroll, your elections are effective through December 31, 2017. If you do not enroll by the end of the 90-day period immediately following the date shown on these materials, you will waive coverage for 2017. You will not be able to make any changes to your coverage or the dependents you cover until open enrollment in the fall of 2017 for coverage effective January 1, 2018, subject to your Special Enrollment Rights (see page 10 of this Guide).

Contact the Plan Office at 303-430-9334 or 800-527-1647 if you encounter problems using the system.

B. Telephone Enrollment Instructions

You can enroll by calling Zenith American Solutions at 303-430-9334 or toll-free at 800-527-1647, Monday through Friday, from 8:30 a.m. to 4:30 p.m., and an enrollment expert will help you enroll right over the telephone.

C. Paper Enrollment Instructions

The Plan also gives you the option to complete and return the enclosed enrollment form to the Plan Office by the end of the 90-day period immediately following the date shown on these materials. If you mail your enrollment form back to the Plan Office, it must be postmarked on or before midnight of the 90th day immediately following the date shown on these materials. Be sure to sign your enrollment form before returning it. You will receive a confirmation statement in the mail once the Plan Office receives your enrollment form and processes your enrollment.

ANNUAL REMINDERS

- **Confidentiality of Your Protected Health Information.** Privacy rules, part of the Health Insurance Portability and Accountability Act (HIPAA) passed by Congress in 1996, became effective for this Plan on April 14, 2003. HIPAA privacy rules apply to those who provide medical services, such as hospitals and doctors and also to HMOs, insurance companies and health plans. These rules are intended to protect your personal information from being inappropriately disclosed. The Plan has provided you with its Notice of Privacy Practices regarding the use and disclosure of your protected health information, also known as PHI. The current notice also clarifies that you will receive notice if a breach of your PHI occurs. You may obtain a copy of the current notice at any time by going to the Plan's website, www.zenith-american.com, or by contacting the Plan Office.

- **Women's Health and Cancer Rights Act of 1998 (WHCRA).** As required by this Act, if the Plan provides benefits to an individual in connection with a mastectomy, the Plan will also provide benefits to that individual for reconstruction of the breast on which a mastectomy is performed, reconstructive surgery on the other breast to achieve a symmetrical appearance, prostheses and treatment of physical complications for all stages of a mastectomy, including lymphedemas.

- **Notice of Prescription Drug Creditable Coverage.** If you and your dependents are covered under the Rocky Mountain UFCW Unions & Employers Health Benefit Plan, you have prescription drug coverage that is, on average, as good as standard Medicare Prescription Drug Coverage. The Plan is required to provide all Medicare-eligible covered individuals with a Notice of Prescription Drug Creditable Coverage each year. If you or your dependent are eligible for Medicare and have not received a copy of this Notice, please contact the Plan Office.

- **Special Extension of Coverage for a Student on a Medically Necessary Leave of Absence.** An extension to continue health care coverage may be available to a seriously ill stepchild (or a child for whom the eligible employee has been awarded custody) who is a college (post-secondary) student who would otherwise lose coverage because he or she did not meet the Plan's full-time student requirements. The Plan will continue coverage for up to one year while the student is on a medically necessary leave of absence provided that:
  - The Plan receives written certification from the physician of the stepchild or the child for whom the eligible employee has been awarded custody that (a) the child is suffering from a serious illness or injury, and (b) the leave of absence (or other change in enrollment) from the post-secondary school is medically necessary; and
  - The loss of student status would cause a loss of health coverage under the Plan's provisions.

  This maximum one-year extension of coverage begins on the first day of the medically necessary leave of absence (or other change in enrollment) and ends on the date that is the earlier of (1) one year later, or (2) the date on which coverage would otherwise terminate under the terms of the Plan. Contact the Plan Office for more information.

- **Notice of Special Enrollment Rights.** The Plan's Special Enrollment Rights govern your rights to add or change your coverage under the Plan. The following information describes when you may add and/or terminate Plan coverage for yourself and/or your eligible dependent(s).
  - **Adding Coverage.** The Plan permits the following special enrollment periods when you may add coverage for yourself and/or your eligible dependent(s).
    - *Loss of Other Coverage.* If you are eligible for benefits but did not enroll yourself, your eligible dependent spouse, and/or your eligible dependent children (eligible dependent) for coverage when you were eligible to do so, you will be allowed to enroll yourself and/or your eligible dependent(s) for coverage ***if*** all of the following four conditions are met:
      1. You and/or your eligible dependent(s) were covered under a different group health plan or health insurance coverage at the time coverage previously was offered;

2. Your and/or your dependent's coverage ended because of:
    a. Loss of eligibility, including legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or change in employment status;
    b. Termination of the employer's contribution toward such other coverage;
    c. Exhaustion of COBRA coverage;
    d. Denial of a claim due to application of an annual limit; or
    e. If coverage was provided by an HMO and you or your eligible dependent are no longer residing, living, or working in the HMO service area and the HMO does not provide coverage for that reason;
3. You request enrollment in this Plan for yourself and/or your eligible dependent(s) no later than 30 days after the date other coverage was lost for one of the reasons listed in item 2 above; and
4. You authorize the necessary self-payment deduction to provide coverage for yourself and/or your eligible dependent(s) at the time enrollment is requested.

» *Acquisition of Eligible Dependent.* Employees, spouses, and dependent children may enroll under the Plan following the acquisition of a new dependent, if ***all*** of the following four conditions are met:

1. You and your dependent(s) are eligible for coverage;
2. A spouse and/or a child becomes your dependent through marriage, birth, adoption, or placement for adoption;
3. You request enrollment for yourself, your spouse (whether or not previously eligible) and/or the child(ren) newly acquired through marriage within 30 days of the event, or if you acquire a child(ren) through birth, adoption or placement for adoption, within 60 days;
4. You authorize the necessary self-payment deduction to provide coverage for yourself and/or your dependent(s) at the time enrollment is requested, and you provide the Plan with any requested information in a timely manner.

To request enrollment, go online to www.zenith-american.com, select **Enrollment**, and then select **Family Status Change**.

» *Loss of Eligibility Under Medicaid or State Children's Health Insurance Program ("SCHIP").* If you are eligible for benefits but did not enroll yourself, your eligible dependent spouse, and/or your eligible dependent children (eligible dependent) for coverage when you were eligible to do so, you will be allowed to enroll yourself and/or your eligible dependent(s) for coverage if all of the following four conditions are met.

1. You and/or your eligible dependent(s) were covered under Medicaid or SCHIP;
2. You and/or your eligible dependent(s) loses eligibility for coverage under Medicaid or SCHIP;
3. You request enrollment in this Plan for yourself and/or your eligible dependent(s) within 60 days of the date Medicaid or SCHIP coverage terminates; and
4. You authorize the necessary self-payment deduction to provide coverage for yourself and/or your eligible dependent(s) at the time enrollment is requested.

- *Eligibility for Financial Assistance Under Medicaid or SCHIP.* If you are eligible for benefits but did not enroll yourself, your eligible dependent spouse, and/or your eligible dependent children (eligible dependent) for coverage when you were eligible to do so, you will be allowed to enroll yourself and/or your eligible dependent(s) for coverage if all of the following three conditions are met:
  1. You and/or your eligible dependent(s) become eligible for financial assistance through Medicaid or SCHIP with respect to coverage under this Plan, for example, through a premium assistance subsidy;
  2. You request enrollment in this Plan for yourself and/or your eligible dependent(s) within 60 days of the date you and/or your eligible dependent(s) become eligible for financial assistance; and
  3. You authorize the necessary self-payment deduction to provide coverage for yourself and/or your eligible dependent(s) at the time enrollment is requested.

- *Effective Date of Coverage.* If the necessary self-payment is authorized in a timely fashion, the effective date of coverage will be, as applicable, the date of:
  1. Marriage;
  2. Birth;
  3. Adoption or placement for adoption;
  4. Loss of coverage; or
  5. No later than the first day of the first calendar month beginning after receipt of a completed request for enrollment in the event of loss of Medicaid or SCHIP coverage or eligibility for financial assistance under Medicaid or SCHIP.

To terminate coverage for yourself and/or your dependent(s), go online to www.zenith-american.com, select **Enrollment**, and then select **Family Status Change**.

– **Terminating Coverage/Disenrollment.** You can terminate coverage for yourself and/or your eligible dependent(s) if:

- *The dependent loses eligibility for coverage under the Plan.* This would include your dependent child reaching the limiting age or terminating full-time student status, the death of your spouse, or your divorce from your spouse; or
- You or your eligible dependent(s) become covered under another plan, including Medicare. However, if you become eligible for other coverage or Medicare, you are required to continue coverage under the Plan for yourself if you wish to continue coverage for your eligible dependent(s).

To request special enrollment or change your enrollment status, go online to www.zenith-american.com, select Enrollment, and then select **Family Status Change**. For more information, please contact the Plan Office by:

Phone: 303-430-9334 or 800-527-1647

Mail:
Rocky Mountain UFCW Unions & Employers Health Benefit Plan
Attn: HIPAA Compliance Unit
P.O. Box 447
Arvada, CO 80001-0447

If this change results in a reduction in the required weekly payroll deduction, you must request the change in coverage within 60 days of the event resulting in the loss of dependent status or eligibility for other coverage, including Medicare. If you do not request the change within 60 days, your weekly payroll deduction will remain in place until the effective date of your next enrollment opportunity.

If you request to terminate coverage for yourself or your eligible dependent due to becoming eligible for other coverage, coverage under the Plan will end on the first day of the month following receipt of all requested information.

If you request to terminate coverage for your dependent due to the dependent no longer satisfying the definition of Dependent set forth in the Plan's Rules and Regulations, coverage for such dependent will end in accordance with the Plan's Rules and Regulations.

- **Working Spouse Weekly Co-payment.** The Plan will permit you to stop payment of the additional $23.08 per week co-payment if:
  - your spouse becomes covered under a plan sponsored or maintained by his/her employer; or
  - your spouse no longer has coverage available through his/her employer (i.e., is no longer working or the employer is no longer providing coverage).

  To request cessation of the working spouse weekly co-payment, you must advise the Plan Office of the occurrence of the above events. In addition you will be eligible for a refund of any working spouse weekly co-payments made after the occurrence of the above events, provided any refund will be limited to the monies withheld during the calendar year in which the refund request was received.

The information in this *Guide* is only a brief summary of certain features of the Rocky Mountain UFCW Unions & Employers Health Benefit Plan. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan provisions, the document language will govern. The Trustees reserve the right to amend, modify, or discontinue all or part of the Plan at any time.

2017 Newly Eligible Enrollment Guide