

Medical Benefits	UnitedHealthcare/UMR PPO Medical Plan	Kaiser Permanente HMO Plan
<b>Preventive Care Services</b>	Note: Plan pays for 100% of preventive appointments and preventive services provided by Network provider, as required under the Affordable Care Act, including the services listed in this section. Charges for additional tests and procedures subject to Plan coinsurance and deductible if covered under the Plan.	
<b>Mammogram</b>	<p><b>Network:</b></p> <ul style="list-style-type: none"> <li>Coverage includes the associated Preventive Outpatient Professional Services</li> <li>Diagnostic-related services are covered at the same level of benefits as other X-ray and lab services, based on place of service</li> <li>Plan pays 100% for preventive appointments and services provided by a Network provider as required under the Affordable Care Act. Charges for additional tests and procedures are subject to Plan coinsurance and deductible if covered under the Plan</li> </ul> <p><b>Non-Network:</b> Plan pays 50% after deductible is met for the following:</p> <ul style="list-style-type: none"> <li><i>Age 50 and over:</i> Plan covers one screening per year</li> <li><i>Age 40 through age 49:</i> Plan covers one screening every two years or one screening each year for women with identified risk factors</li> <li><i>Age 35 through age 39:</i> Plan covers one baseline mammogram</li> <li><i>Under age 35:</i> Not covered</li> </ul>	Plan pays 100% as required under the Affordable Care Act
<b>Immunization</b> (There are special rules for flu shots. See your Enrollment Guide for more information)	<p><b>Network:</b> Plan pays 100% as required under the Affordable Care Act</p> <p><b>Non-Network:</b> Not covered</p>	Plan pays 100% as required under the Affordable Care Act
<b>Bone Mass Measurement Test</b>	<p><b>Network:</b> Plan pays 100% as required under the Affordable Care Act</p> <p><b>Non-Network:</b> Not covered</p>	Plan pays 100% as required under the Affordable Care Act
<b>Routine Annual Physical Exam and Pelvic Examination</b>	<p><b>Network:</b></p> <ul style="list-style-type: none"> <li><i>Ages 3 and above:</i> Plan pays 100% for one exam per year</li> </ul> <p>For diagnostic lab tests and procedures performed and/or ordered during or as a result of the Routine Annual Physical Exam, Plan pays 65% after deductible is met</p> <p><b>Non-Network:</b> Not covered</p> <p>For diagnostic lab tests and procedures performed and/or ordered during or as a result of the Routine Annual Physical Exam, Plan pays 50% after deductible is met</p>	Plan pays 100% as required under the Affordable Care Act
<b>Papanicolaou (Pap) Smear</b>	<p><b>Network:</b> Plan pays 100% for one exam per year</p> <p><b>Non-Network:</b> Plan pays 50% after deductible is met</p>	Plan pays 100% as required under the Affordable Care Act
<b>Prostate-Specific Antigen (PSA) Testing, Including Digital Rectal Exam (DRE)</b>	<p><b>Network:</b></p> <ul style="list-style-type: none"> <li><i>Age 40 and over:</i> Plan pays 100% for baseline exam; one exam per year after that</li> <li><i>Age 39 and under:</i> Plan pays 65% after deductible is met</li> </ul> <p><b>Non-Network:</b> Plan pays 50% after deductible is met</p>	Plan pays 100% as required under the Affordable Care Act

Preventive Care Services continued on next page

For Participants With PPO Plan or Kaiser Permanente HMO Plan Coverage		
<b>Vision Benefits</b>	For All Eligible, Covered Participants and Dependents	
<b>Exam, Frames, and Single Lenses</b>	Once every 2 years \$240	If you are enrolled in Kaiser Permanente HMO Plan coverage, in addition to the coverage listed here, the Plan also covers wellness and refraction eye exams performed by a Kaiser Permanente HMO optometrist for a \$40 co-pay.
<b>Bifocal Lenses</b>	\$260	
<b>Trifocal Lenses</b>	\$290	
<b>Contact Lenses</b>	\$240	
<b>Dental Benefits</b>	For All Eligible, Covered Participants and Dependents	
<b>Preventive and Diagnostic</b>	<b>DPO Provider:</b> Plan pays 100% <b>Non-DPO Provider:</b> Plan pays 80%	
<b>Restorative, Oral Surgery, Endodontics, Periodontics</b>	Not covered	
<b>Prosthetic</b>	Not covered	
<b>TMJ Benefits</b>	Not covered	
<b>Calendar Year Maximum (non-orthodontic)</b>	\$1,000 per employee or dependent age 18 and over; no maximum for dependents under age 18	
<b>Orthodontic Benefits</b>	Not covered	
<b>Weekly Disability Benefits</b>	For All Eligible, Covered Participants	
<b>Benefit Amount</b>	70% of average weekly earnings	
<b>Weekly Maximum</b>	\$300	
<b>Benefits Begin</b>	8th consecutive day of disability or day after employer's benefits end	
<b>Maximum Duration</b>	26 weeks	
<b>Death Benefits</b>	For All Eligible, Covered Participants	
<b>Benefit Amount</b>	\$10,000	
<b>AD&amp;D Benefits</b>	For All Eligible, Covered Participants	
<b>Full Amount</b>	\$10,000	
<b>Life or Combination of Any Below</b>	\$10,000	
<b>One Hand, One Foot, One Eye</b>	\$5,000	
<b>Contact the Plan Office for other covered losses</b>		
<p><i>This is only a brief summary of certain features of the Rocky Mountain UFCW Unions &amp; 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.</i></p>		

## BENEFITS SUMMARY FOR PLAN C—EFFECTIVE JANUARY 1, 2021

The following table provides only a summary of the benefits available under Plan C, effective January 1, 2021. Not all exclusions and limitations are shown. Please refer to your Summary Plan Description (SPD) and any Plan change notices for a complete description of your benefits. Also, refer to your Collective Bargaining Agreement (CBA) for more specific information as to how and when you and your dependents are eligible for coverage and what that coverage will be. Please note that the information about dependents in this chart only applies if your dependents are eligible for coverage. **You are only eligible to enroll in the Kaiser Permanente HMO Plan if you live or work in the Kaiser Permanente HMO service area.**

Medical Benefits	UnitedHealthcare/UMR PPO Medical Plan	Kaiser Permanente HMO Plan
<b>Network</b>	UnitedHealthcare Choice Plus	Kaiser Foundation Health Plan of Colorado No Non-Network benefits except in emergency
<b>Calendar Year Maximum</b>	No maximum	No maximum
<b>Calendar Year Deductible</b>	\$700 per person; three individual deductibles per family	\$750 per person; \$2,250 per family
<b>Calendar Year Out-of-Pocket Limit</b> (includes deductibles, coinsurance, and co-payments for medical and prescription drug benefits)	<b>Network:</b> \$6,350 per person; up to \$12,700 per family <b>Non-Network:</b> No per-person limit; no family limit	\$4,500 per person; \$9,000 per family
<b>Calendar Year Coinsurance Limit</b> (deductible and co-pays not included)	<b>Network:</b> \$4,000 per person; up to \$7,000 per family <b>Non-Network:</b> \$12,000 per person; no family limit	Not applicable
<b>Coinsurance</b> (unless stated otherwise)	<b>Network:</b> Plan pays 65% after deductible is met <b>Non-Network:</b> Plan pays 50% after deductible is met	Plan pays 65% after deductible is met, except: <ul style="list-style-type: none"> <li><b>Diagnostic Lab:</b> Plan pays 100%; no deductible</li> <li><b>Ambulance:</b> Plan pays 65% up to \$500 per trip; no deductible</li> <li><b>Skilled Nursing Facility:</b> Plan pays 65% after deductible is met; up to 100 days per year</li> </ul>
<b>Primary Care Physician (PCP) Office Visit and Telehealth* Visit Co-Payment</b> (applies to office visits for outpatient mental health and substance abuse treatment)	<b>Network:</b> Plan pays 100% after \$40 per visit co-pay; no deductible For procedures received during the office visit, Plan pays 65% after deductible is met <b>Non-Network:</b> Plan pays 50% after deductible is met; Non-Network telehealth visits are not covered	<ul style="list-style-type: none"> <li>Primary Care Physician (PCP): \$40 per visit co-pay</li> <li>Specialist: \$50 per visit co-pay</li> <li>Telehealth: <ul style="list-style-type: none"> <li>Online chat with a Kaiser Permanente doctor: Plan pays 100%</li> <li>Video visit with a Kaiser Permanente PCP or Specialist: Plan pays 100%</li> </ul> </li> </ul> For procedures received during visit, Plan pays 65% after deductible is met
<b>Premium Care Specialist Physician Office Visit Co-Payment**</b>	<b>Network:</b> Plan pays 100% after \$50 per visit co-pay; no deductible For procedures received during the office visit, Plan pays 65% after deductible is met <b>Non-Network:</b> Plan pays 50% after deductible is met	Not applicable
<b>Non-Premium Care Specialist Physician Office Visit Co-Payment**</b>	<b>Network:</b> Plan pays 100% after \$60 per visit co-pay; no deductible For procedures received during the office visit, Plan pays 65% after deductible is met <b>Non-Network:</b> Plan pays 50% after deductible is met	Not applicable

\*Telehealth visits for mental health and substance abuse treatment are not covered.

\*\*Go to [www.umar.com](http://www.umar.com) to find Premium Care Specialist Physicians in the UnitedHealthcare Choice Plus Network. If there is not a Premium Care Specialist in the required field near you, please contact UnitedHealthcare/UMR to locate a specialist and discuss the applicable co-payment.

Medical Benefits	UnitedHealthcare/UMR PPO Medical Plan	Kaiser Permanente HMO Plan
<i>Preventive Care Services (continued)</i>		
<b>Preventive Colonoscopy</b>	<b>Network:</b> Plan pays 100% for exam as required under the Affordable Care Act <b>Non-Network:</b> Plan pays 50% after deductible is met	Plan pays 100% as required under the Affordable Care Act
<b>Well-Baby Care</b> (from birth up to the age of 3) Includes routine physical exams	<b>Network:</b> Plan pays 100% For diagnostic lab tests and procedures performed and/or ordered during or as a result of the well-baby visit, Plan pays 65% after deductible is met <b>Non-Network:</b> Not covered For diagnostic lab tests and procedures performed and/or ordered during or as a result of the well-baby visit, Plan pays 50% after deductible is met	Plan pays 100% as required under the Affordable Care Act
<b>Emergency Room Services</b>	<b>Network:</b> Plan pays 65% after deductible is met <b>Non-Network:</b> Plan pays 65% after deductible is met For non-emergency services provided in a Non-Network emergency room setting, Plan pays 50% after deductible is met	Plan pays 65% after deductible is met
<b>DispatchHealth</b>	Available in the Denver/Boulder and Colorado Springs areas Plan pays 65% after deductible is met	Available in the Denver/Boulder, Longmont and Colorado Springs areas Plan pays 65% after deductible is met
<b>Outpatient Advanced Radiology Procedures</b> (MRIs, X-rays, CAT and PET scans)***	<b>Network:</b> Plan pays 65% after deductible is met and \$75 co-pay is made per day <b>Non-Network:</b> Plan pays 50% after deductible is met and \$75 co-pay is made per day	Plan pays 65% after deductible is met
<b>Inpatient Hospital Services***</b>	<b>Network:</b> Plan pays 65% after deductible is met <b>Non-Network:</b> Plan pays 50% after deductible is met	Plan pays 65% after deductible is met
<b>Outpatient Surgical Services***</b>	<b>Network:</b> Plan pays 65% after deductible is met <b>Non-Network:</b> Plan pays 50% after deductible is met	Plan pays 65% after deductible is met
<b>Durable Medical Equipment***</b>	<b>Network:</b> Plan pays 65% after deductible is met <b>Non-Network:</b> Plan pays 50% after deductible is met Foot and ankle orthotics limited to \$120 maximum for one pair per lifetime	Plan pays 65% after deductible is met <b>Prosthetic Arms and Legs:</b> Plan pays 80%; no calendar year maximum
<b>Hospice</b>	Plan pays 65% after deductible is met	Plan pays 100% Not covered outside of service area
<b>Home Health Care***</b>	Plan pays 65% after deductible is met <b>Calendar Year Maximum:</b> 40 days	Plan pays 65% after deductible is met Not covered outside of service area; limited to less than 8 hours per day and 28 hours per week
<b>Physical, Occupational, and Speech Therapy***</b> (Special rules apply to Speech Therapy)	<b>Outpatient Network:</b> Plan pays 65% after deductible is met <b>Outpatient Non-Network:</b> Plan pays 50% after deductible is met <b>Speech Therapy:</b> <ul style="list-style-type: none"> <li>Hospital Speech Therapy: Same as above</li> <li>Speech Pathologist (Non-Hospital): Plan pays 50% after deductible is met</li> <li>Outpatient Calendar Year Limit: 50 days</li> </ul>	For physical, occupational, and speech therapy, Plan pays: <ul style="list-style-type: none"> <li><b>Inpatient:</b> 65% after deductible is met; multi-disciplinary facilities are limited to 60 days per condition, per year</li> <li><b>Outpatient:</b> \$40 per visit co-pay; no deductible, up to 20 visits per year for each type of therapy</li> </ul>

\*\*\*Precertification is required for these and other services like outpatient surgery, imaging, and dialysis. Services that require precertification are determined by UnitedHealthcare/UMR and are subject to change from time to time. Please call UnitedHealthcare/UMR at 866-494-4502 for the current list of services requiring precertification.

Medical Benefits	UnitedHealthcare/UMR PPO Medical Plan	Kaiser Permanente HMO Plan
<b>Mental Health Treatment****</b>		Non-biologically based
<b>Inpatient</b>	<b>Network:</b> Plan pays 65% after deductible is met <b>Non-Network:</b> Plan pays 50% after deductible is met	Plan pays 65% after deductible is met
<b>Outpatient</b>	<b>Network:</b> <ul style="list-style-type: none"> <li>Office Visits: Plan pays 100% after \$40 per visit co-pay; no deductible</li> <li>Outpatient Facility: Plan pays 65% after deductible is met</li> </ul> <b>Non-Network:</b> Plan pays 50% after deductible is met Inpatient and certain other Mental Health Treatments are authorized and managed by MINES & Associates For diagnostic lab tests and procedures performed and/or ordered during or as a result of the office visit, Plan pays coinsurance after deductible is met	\$40 per visit co-pay; no deductible 50% of office visit copay for group visits
<b>Substance Abuse Treatment****</b>		Non-biologically based
<b>Inpatient</b>	<b>Network:</b> Plan pays 65% after deductible is met <b>Non-Network:</b> Plan pays 50% after deductible is met	Plan pays 65% after deductible is met
<b>Outpatient</b>	<b>Network:</b> <ul style="list-style-type: none"> <li>Office Visits: Plan pays 100% after \$40 per visit co-pay; no deductible</li> <li>Outpatient Facility: Plan pays 65% after deductible is met</li> </ul> <b>Non-Network:</b> Plan pays 50% after deductible is met Inpatient and certain other Substance Abuse Treatments are authorized and managed by MINES & Associates For diagnostic lab tests and procedures performed and/or ordered during or as a result of the office visit, Plan pays coinsurance after deductible is met	\$40 per visit co-pay; no deductible 50% of office visit copay for group visits
<b>Chiropractic Benefits</b>	<b>Network:</b> Plan pays 65% after deductible is met <b>Non-Network:</b> Plan pays 50% after deductible is met Chiropractic benefits limited to 15 visits per year	\$40 per visit co-pay (must use Kaiser Permanente chiropractors) Chiropractic benefits limited to 15 visits per year
<b>Transplant Benefits</b>	<b>Optum Designated Transplant Facility:</b> Plan pays 100% after deductible is met <b>Network:</b> Plan pays 65% after deductible is met <b>Non-Network:</b> Plan pays 50% after deductible is met <b>Per-Transplant Maximums:</b> Organ Procurement (inclusive of provider contract): \$10,000 per donor (does not apply to Optum transplant) <b>Transportation/Lodging:</b> \$7,500 (costs incurred if transplant is performed within 100 miles of home will be excluded)	Plan pays 65% after deductible is met

\*\*\* Precertification is required for these and other services like outpatient surgery, imaging, and dialysis. Services that require precertification are determined by UnitedHealthcare/UMR and are subject to change from time to time. Please call UnitedHealthcare/UMR at 866-494-4502 for the current list of services requiring precertification.

\*\*\*\*MINES & Associates is the Network (PPO) Provider for these treatments and performs any required precertification on such services.

Prescription Drug Benefits	PPO Medical Plan Through Express Scripts, Inc.	Kaiser Permanente HMO Plan
<b>Mandatory Generic Program</b>	You must use generic drugs whenever they are available. If you do not, you must pay the generic drug co-pay plus the difference in cost between the generic medication and the brand name medication. See your Summary Plan Description for more information.	Not applicable
<b>Participating Retail Pharmacy</b>	Per 34-day supply or 100-unit dose, you pay:	Per 30-day supply, you pay:
Generic	\$5 co-payment per prescription	\$15 co-pay per prescription
Preferred Brand	20% up to \$50 per prescription	\$30 co-pay per prescription
Non-Preferred Brand	30% up to \$75 per prescription	Not covered
Specialty	20% up to \$100 per prescription	Covered under the applicable co-pay
<b>90-day Supply</b>		<b>Maintenance Medications</b>
Generic	\$10 co-payment per prescription	\$30 co-pay per prescription
Preferred Brand	20% up to \$100 per prescription	\$60 co-pay per prescription
Non-Preferred Brand	30% up to \$150 per prescription	Not covered
	No Mail-Order Program available	Call Kaiser for more information about covered maintenance medications Available through the Mail-Order Program
Prescription medications required to be covered at 100% by the Affordable Care Act are covered 100% by the Plan		
<b>Non-Participating Pharmacy</b>	Not covered, except in emergency	Not covered, except in emergency
<b>Maximum Supply</b>	Greater of 34-day supply or 100 unit dose, unless a physician writes a prescription for a 90-day supply	<b>Retail:</b> 30-day supply <b>Mail Order:</b> 90-day supply; certain medications may be limited to a 30-day supply
<b>Dependent Coverage</b>	<b>UnitedHealthcare/UMR PPO Medical Plan</b>	<b>Kaiser Permanente HMO Plan</b>
<b>Dependent Children</b>	Last day of the month in which the dependent child turns age 26 (or, if a stepchild or a child for whom the eligible employee has been awarded custody, December 31 of the year the child attains age 19 or age 23 if a full-time student)	Last day of the month in which the dependent child turns age 26
<b>Spouse/Civil Union Partner</b>	Lawful spouses, including common law spouses, covered; civil union partners not covered	Lawful spouses, including common law spouses, and civil union partners covered