Rocky Mountain
UFCW Unions &
Employers
**HEALTH
BENEFIT PLAN**

2021 Open Enrollment Guide

Your Benefits
Your Options
Your Choice

The Open Enrollment Period for 2021 Coverage Ends October 31, 2020

EXPRESS LANE to Good Health
Rocky Mountain UFCW Unions & Employers Health Benefit Plan
Healthcare Management Program

2021 Enrollment Guide

Each fall during Open Enrollment, you have the opportunity to:

- Enroll for Plan coverage for the coming year.
- Change your current Plan election.
- Add or remove dependents from coverage.
- Notify the Plan Office if any of your dependents have become eligible for other coverage or there is a change in the other coverage. (For example, if your spouse has become entitled to other coverage, you must notify the Plan Office.)

Don't forget to update dependent information, including eligibility for other coverage and your spouse's employment status.

ARE YOU ENROLLING YOUR SPOUSE FOR PLAN COVERAGE AS A DEPENDENT?

If you want to continue coverage for your spouse, you must complete a Spousal Verification Form (included with your enrollment packet). If your spouse was not enrolled in the Plan in 2020 but you will be enrolling your spouse for Plan coverage in 2021, you must complete an Enrollment Form and the Spousal Verification Form included with your enrollment packet.

Please remember that you must verify your spouse's eligibility for other coverage, every year, regardless of whether your spouse is currently or was ever covered by the Plan, if you want your spouse to have coverage through the Plan in the following year.

If your spouse is eligible for coverage under his/her employer-sponsored plan but elects not to enroll in that plan, an additional $23.08 weekly co-premium deduction is currently required. To avoid this additional weekly co-premium deduction, your spouse must be enrolled in his/her employer-sponsored plan. Otherwise, your weekly co-premium 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.

Important Reminder

The Plan mailed you a letter showing your current coverage and your covered dependents, if any. Review the letter before you decide on your 2021 coverage. If you notice that one of your dependents who has coverage under the Kaiser Permanente HMO Plan is not listed in the letter, please contact the Plan Office immediately.

If you want to change your coverage or the dependents you cover, or there has been a change in your dependents' eligibility for other coverage, you must actively enroll. In addition, if you or any of your dependents become eligible for other coverage or there is a change in the other coverage, you must notify the Plan Office immediately.

If you are enrolling for coverage for the first time or did not have coverage under the Plan in 2020, you must actively enroll. If you do not enroll by midnight October 31, 2020, you will not have coverage under the Plan in 2021, subject to your Special Enrollment Rights (see page 11 of this Guide). Your next opportunity to enroll for coverage will be during Open Enrollment in the fall of 2021 for coverage effective January 1, 2022, subject to your rights set forth in the Notice of Special Enrollment Rights (starting on page 11 of this Guide).

If you do not want to make any changes to your coverage election of the PPO or HMO option and you do not want to make any changes to the dependents you cover, ***you only need to complete the steps related to verifying your spouse's coverage, if you are covering your spouse. If you are not covering your spouse, you don't need to do anything.*** The Plan will automatically continue your current coverage option and your weekly employee deductions in 2021. Your coverage will be subject to the terms and conditions, including any modifications to the Plan Options, approved by the Trustees and effective January 1, 2021.

ABOUT THIS GUIDE

This *2021 Enrollment Guide* is designed to help you make informed decisions about your benefits and to complete the enrollment process.

Please take the time to review this *2021 Enrollment Guide* carefully. It is up to you to understand your benefits and how they work, and to complete your enrollment for 2021 by midnight October 31, 2020.

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

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.

SAVE $$$$: Whether you elect coverage in the UnitedHealthcare/UMR PPO Medical Plan or the Kaiser Permanente HMO Plan, you have to complete a Health Assessment by December 4, 2020, to be eligible for a monthly co-premium reduction in 2021. This applies whether or not you are making any other changes to your coverage. See page 5 for more information.

YOUR 2021 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, subject to your Special Enrollment Rights (see page 11 of this Guide).

The Plan offers two medical programs for you to choose from. However, the Trustees are not recommending one program over the other. You should make your election based on your own circumstances, and the Trustees encourage you to review whether your current providers are in the network.

- **UnitedHealthcare/UMR PPO Medical Plan.** The UnitedHealthcare/UMR PPO Medical Plan provides you with comprehensive medical benefits coverage. Each time you receive care, you have the choice of using a provider through the UnitedHealthcare/UMR Choice Plus network or a non-network provider. If you enroll in the UnitedHealthcare/UMR PPO, your prescription drug benefits will be administered by Express Scripts, Inc. (ESI).
- **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 in order for your care to be covered under the HMO Plan, 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 Kaiser Permanente HMO 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 UnitedHealthcare/ UMR PPO Medical 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.

Network Pharmacies

The Plan has contracted with a network of retail pharmacies (called participating pharmacies) including:

- Albertsons
- King Soopers
- City Market
- Safeway

If you go to a pharmacy that is not in the network, your prescription will not be covered by the Plan.

To locate a UnitedHealthcare/UMR Choice Plus network doctor or Express Scripts retail pharmacy in your area, check their websites (refer to page 2 for contact information). You can also contact Express Scripts or UnitedHealthcare/UMR if your pharmacy or doctor is not in their network and you'd like to nominate them for network participation.

Who to Contact

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 issues	Plan Office (Zenith American Solutions) *Physical Address:* 5511 West 56th Avenue, Suite 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**
UnitedHealthcare Choice Plus PPO medical network providers	UnitedHealthcare/UMR	800-826-9781	**www.umr.com**
Utilization review		866-494-4502	
Telehealth services	Teladoc	800-Teladoc	**www.teladoc.com**
PPO prescription drug benefits	Express Scripts, Inc.	844-863-5330	**www.express-scripts.com**
Mental health and substance abuse treatment PPO network and utilization review provider	MINES & Associates	800-873-7138 *or* 303-832-1068	**www.minesandassociates.com**
HMO medical network providers, utilization review, and prescription drug benefits	Kaiser Permanente (Group 8600/Plan 620)	800-632-9700 *or* 303-338-3800	**www.kp.org**
Urgent care at home—DispatchHealth—If you live outside the areas noted, please contact Kaiser Permanente HMO or UnitedHealthcare/UMR Medical Plan to determine if DispatchHealth is available in your area.	DispatchHealth	Kaiser Permanente HMO: • Denver/Boulder/Longmont: 303-500-1518 • Colorado Springs: 719-270-0805 UnitedHealthcare/UMR PPO Medical Plan: • Denver/Boulder: 720-738-9539 • Colorado Springs: 719-401-0147	**www.dispatchhealth.com**
Dental benefits	Delta Dental	800-610-0201 *or* 303-741-9305	**www.deltadentalco.com**
Life or AD&D insurance benefits	Union Labor Life Insurance Company (Ullico) 8403 Colesville Road, 13th Floor Silver Spring, MD 20910	202-682-0900	**www.ullico.com**

Enrollment Reminders

Whether you elect coverage in the UnitedHealthcare/UMR PPO Medical Plan or the Kaiser Permanente HMO Plan, you have to fully complete a Health Assessment by December 4, 2020, to be eligible for a monthly co-premium reduction in 2021 whether or not you are making any other changes to your coverage.

If you don't complete a Health Assessment, you'll pay the full co-premium effective January 1, 2021—even if you completed a Health Assessment and your co-premium was reduced in 2020. See page 5 for more information.

Your enrollment package includes the following:

- A Spousal Verification Form;
- A benefits summary showing the benefits you are eligible to receive;

- An Enrollment Form; 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 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 document language will govern.

You should have already received a letter from the Plan that shows your current coverage and your covered dependents, if any. This letter used to be included with your enrollment package. Make sure to review the letter before you decide on your 2021 coverage. If you notice that one of your dependents who has coverage under the Kaiser Permanente HMO Plan is not listed in the letter, please contact the Plan Office immediately.

Kaiser Permanente HMO Service Area

If you live or work in a Kaiser Permanente HMO service area, you may be eligible to enroll in the Kaiser Permanente HMO Plan option. Please note that when you enroll, you must provide a valid street address as your place of residence. P.O. boxes are not accepted.

Enclosed with your Open Enrollment packet is a benefit summary for the plan option(s) that you are eligible to enroll in for coverage in 2021. If you live in the Kaiser Permanente HMO service area, your benefit summary will show both the UnitedHealthcare/UMR PPO Medical Plan option and the Kaiser Permanente HMO Plan option. If you live outside the Kaiser Permanente HMO service area, your benefit summary will only show the UnitedHealthcare/UMR PPO Medical Plan option. However, if you just work in the Kaiser Permanente HMO service area but do not live there, you may still be eligible to enroll in the Kaiser Permanente HMO Plan. Please contact the Plan Office for an Enrollment Form if you wish to enroll in the Kaiser Permanente HMO Plan; your enrollment is subject to Kaiser's review and approval.

Always contact Kaiser Permanente to check if you are eligible for coverage at certain provider locations.

DispatchHealth—An Urgent Care Visit at Home (generally limited to the Denver/Boulder and Colorado Springs service areas)

Both the UnitedHealthcare/UMR PPO Medical Plan and the Kaiser Permanente HMO Plan are partnering with DispatchHealth to better serve you and provide convenient, cost-effective care options.

Participants in the Denver/Boulder and Colorado Springs service areas may request urgent care at home from DispatchHealth (participants electing coverage under Kaiser Permanente HMO who live in Longmont also have access to DispatchHealth). Participants may also be referred to DispatchHealth through Kaiser Permanente's or UnitedHealthcare/UMR's medical advice line or chat. If you request a visit from DispatchHealth but another care option may be more appropriate, DispatchHealth will triage you before sending their care team.

A DispatchHealth visit will be paid on the same basis as an urgent care visit.

Operating hours are from 8 a.m. to 10 p.m. (subject to provider availability). To contact DispatchHealth:

Kaiser Permanente HMO Plan:

- Denver/Boulder/Longmont: 303-500-1518
- Colorado Springs: 719-270-0805
- **www.dispatchhealth.com**

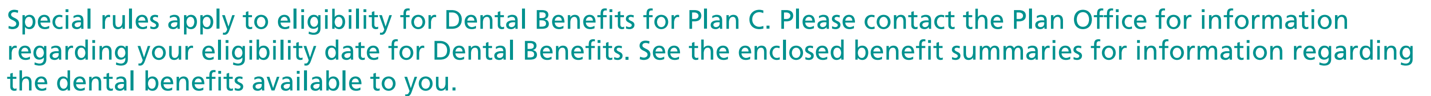
UnitedHealthcare/UMR PPO Medical Plan:

- Denver/Boulder: 720-738-9539
- Colorado Springs: 719-401-0147
- **www.dispatchhealth.com**

If you live outside the areas noted above, please contact Kaiser Permanente HMO or UnitedHealthcare/UMR Medical Plan to determine if DispatchHealth is available in your area.

DENTAL BENEFITS

Special rules apply to eligibility for Dental Benefits for Plan C. Please contact the Plan Office for information regarding your eligibility date for Dental Benefits. See the enclosed benefit summaries for information regarding the dental benefits available to you.



ADDING A DEPENDENT FOR PLAN COVERAGE?

Participants who are adding dependents for Plan coverage—even if the dependents had coverage under the Plan before but are not currently covered by the Plan—are required to submit documentation to the Plan Office. If you add 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. Only your dependents that meet the Plan's definition of eligible dependents may be enrolled.

Kaiser Permanente's definition of "dependent" differs for a stepchild or a child under legal guardianship. Kaiser Permanente 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. 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 such child will be the next enrollment in Fall 2021.

Make sure to review the letter that the Plan mailed you separately showing your current coverage and your covered dependents, if any. If anything in the letter is incorrect, please call the Plan Office right away. If you do not alert us to changes, you are certifying that the information is correct. If you or any of your dependents become eligible for other coverage or there is a change in the other coverage, please contact the Plan Office immediately. (For example, if your spouse is entitled to other coverage, please notify the Plan Office immediately.)

REMEMBER TO COMPLETE YOUR ANNUAL HEALTH ASSESSMENT AND REDUCE YOUR MONTHLY MEDICAL CO-PREMIUMS FOR 2021

Active participants and spouses with current coverage through the UnitedHealthcare/UMR PPO Medical 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. While Open Enrollment ends on midnight October 31, 2020, you have until December 4, 2020, to complete your Health Assessment and be eligible for a monthly medical co-premium reduction in 2021.

If either you or your enrolled spouse completes a Health Assessment on or before December 4, 2020, you will receive a $5 monthly co-premium reduction effective January 1, 2021, through December 31, 2021. If you both complete Health Assessments on or before December 4, 2020, you will receive a $10 monthly co-premium reduction in 2021.

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 discuss with your doctor. You'll also get suggestions for improving your health.

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?

UnitedHealthcare/UMR Clinical Health Risk Assessment: Go to **www.umr.com** or scan the QR code to the right. Then log in or register, and look for the Clinical Health Risk 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.**

Note: You can also complete a paper assessment if you have UnitedHealthcare/UMR coverage, though it will take longer to get your results. Call the Plan Office for more information.

Are you switching from Kaiser to UnitedHealthcare or vice versa, or enrolling yourself or your spouse for Plan coverage for the first time during this Open Enrollment? If so, you may have to complete a paper 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, you'll pay the full co-premium effective January 1, 2021.

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

HOW YOUR MEDICAL COVERAGE WORKS

<table>
<tr><th>Feature</th><th>UnitedHealthcare/UMR PPO</th><th>Kaiser Permanente HMO</th></tr>
<tr><td>Providers</td><td>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.</td><td>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.</td></tr>
<tr><td>Network</td><td>UnitedHealthcare Choice Plus Preferred Provider Organization (PPO). To locate a Network Provider, contact UnitedHealthcare/UMR directly by:
• Visiting www.umr.com; or
• Calling 800-826-9781.
Remember to look for providers who are Premium Care Physicians. To locate a Premium Care Physician, select People then select Specialty Care
To locate an Express Scripts, Inc. network retail pharmacy, call 844-863-5330.</td><td>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).</td></tr>
<tr><td>Deductible</td><td>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 benefits.</td><td>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.</td></tr>
<tr><td>Coinsurance</td><td>Once you or your family (if applicable) meets the annual Deductible, the Plan pays a percentage of Covered Expenses, and you pay the rest. The Coinsurance percentage 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 whether you use Network or Non-Network Providers and is a different amount per person and per family.</td><td>Once you or your family (if applicable) meets the annual Deductible, the Plan pays a percentage of Covered Expenses, and you pay the rest. The Coinsurance percentage varies, depending on the covered service provided.</td></tr>
<tr><td>Co-payments</td><td>When you or a family member (if applicable) goes 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 toward meeting the Out-of-Pocket Limit.</td><td>For certain services, you or a family member (if applicable) pays 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) is responsible for paying these Co-payments even if you have met your Deductible and Out-of-Pocket Limit.</td></tr>
<tr><td>Out-of-Pocket Limit</td><td>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 Out-of-Pocket Limit 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.</td><td>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 Limit.</td></tr>
</table>

WEEKLY CO-PREMIUM DEDUCTIONS FOR COVERAGE

To be covered under the Plan, weekly co-premium deductions are required for coverage. Co-premium rates, including the additional working spouse co-premium rate, are subject to change. By completing the enrollment process, you are authorizing your agreement to the weekly co-premium deductions from your paycheck. If you don't take any action, your current coverage will continue. The weekly co-premium deduction depends on the level of coverage you elect, as follows:

Coverage Level	Weekly Co-Premium 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

If Both You and Your Spouse Are Employees

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 co-premium deduction per person).
- If you have dependent children—One of you should elect Employee-Only coverage (a $7.50 per week co-premium deduction), and the other should elect Employee and Dependent Child(ren) coverage (a $15.00 per week co-premium deduction).

Please note that 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.

Additional Working Spouse Co-Premium

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 co-premium deduction is currently required. To avoid this additional weekly co-premium deduction, your spouse must be enrolled in his/her employer-sponsored plan. Otherwise, your weekly co-premium 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).

ENROLLMENT 2021

Continuing Your Current Coverage

You previously received a letter showing your current coverage and your covered dependents, if any. Remember to review the letter before you decide on your 2021 coverage. If you notice that one of your dependents who has coverage under the Kaiser Permanente HMO is not listed in the letter, please contact the Plan Office immediately. Unless you notify the Plan Office to the contrary, you are certifying that the dependents listed in the letter qualify as eligible dependents under the Plan.

Remember, you have to complete a Health Assessment to be eligible for a monthly co-premium reduction whether or not you are making any other changes to your coverage. See page 5 for more information about the Health Assessment.

You are required to notify the Plan Office if you or your dependents have a change in other health insurance coverage (such as your spouse losing coverage under his or her employer's coverage).

If you do not want to make any changes to your coverage election of the PPO or HMO option and you do not want to make any changes to the dependents you cover, you only need to complete the steps related to verifying your spouse's coverage, if you are covering your spouse. If you are not covering your spouse, you don't need to do anything. The Plan will automatically continue your current coverage option and your weekly employee deductions in 2021. Your coverage will be subject to the terms and conditions, including any modifications to the Plan Options, approved by the Trustees and effective January 1, 2021.

If you are enrolling for the first time, changing your coverage or the dependents you cover, or there has been a change in your dependent's eligibility for other coverage, 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 2021, make your benefits decisions together, and then enroll. (See below for enrollment instructions.) **You must enroll by midnight October 31, 2020, in order for your changes to be effective January 1, 2021.**

Waiving Coverage for 2021

If you are currently covered by the Plan and wish to waive coverage for 2021, you will have to complete the enrollment process online, by telephone, or with the enclosed paper Enrollment Form. If you do not actively waive your coverage for 2021, the Plan will automatically continue your current coverage election (PPO or HMO), as well as continue your weekly co-premium deductions.

If you 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, or AD&D coverage.

Changing Your Enrollment Elections Before Midnight October 31, 2020

You can change your enrollment elections any time before midnight October 31, 2020; however, the Plan Office must have any changes before midnight October 31, 2020, in order for them to take effect on January 1, 2021. Please note that if you enroll by completing and submitting an Enrollment Form, you may not receive your enrollment confirmation as quickly as when you enroll by telephone or online. In addition, if you submit an Enrollment Form, you may not receive your confirmation before midnight October 31, 2020, and therefore, you may not be able to modify your enrollment elections.

Are you adding dependents for Plan coverage?

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

How to Enroll—Three Easy Options

1. Online Enrollment Instructions

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

- Review and update your personal and dependent information, including eligibility for other coverage.
- Enroll for benefits for 2021, including selecting the level of coverage that is right for you.
- Add and/or terminate coverage for your eligible dependents.
- Change your beneficiary (or beneficiaries) for your life and AD&D benefits.

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 through midnight October 31, 2020.

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.

- **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, 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. You can also call the Plan Office for tips and resources.

- **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, 7 days a week.

- **Log In to the Site**

  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.

  First Time Using the Online System?

  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 email 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.

- **Enter Your 2021 Enrollment Elections**

  Once you log in to the site, what you see will vary depending on whether or not you are currently enrolled. Follow the step-by-step instructions on the enrollment site.

- **After Enrolling**

  After you enroll, you can enter the online enrollment system to make changes to your election any time before midnight October 31, 2020. After that time, the system is closed for Open Enrollment, and no changes can be made unless you meet the Plan's Special Enrollment Rights provision (starting on page 11).

  Once you enroll, your elections are effective January 1, 2021, through December 31, 2021. If you do not enroll by midnight October 31, 2020, the Plan will automatically continue your current coverage and your weekly employee deductions in 2021. You will not be able to make any changes to your coverage or the dependents you cover until Open Enrollment in the fall of 2021, subject to your Special Enrollment Rights (see page 11 of this *Guide*).

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

2. **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.

3. **Paper Enrollment Instructions**

   The Plan also gives you the option to complete and return the enclosed Enrollment Form to the Plan Office by midnight October 31, 2020. If you mail your Enrollment Form back to the Plan Office, it must be postmarked on or before midnight October 31, 2020. 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 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 is eligible for Medicare and has 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 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 dependents' 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 is 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 co-premium 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, placement for adoption, or your eligible dependent comes to the United States on a valid visa;

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 within 30 days of a dependent's entry into the United States on a valid visa, if you acquire a child(ren) through birth, adoption, or placement for adoption, within 60 days; and

4. You authorize the necessary co-premium 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.

Dependents who come to the United States on a valid visa may be considered eligible dependents.

» *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) lose 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 co-premium 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 co-premium 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 co-premium is authorized in a timely fashion, the effective date of coverage will be, as applicable, the date of:
  1. Loss of other coverage;
  2. Marriage;
  3. Birth;
  4. Adoption or placement for adoption;
  5. Dependent's entry into the United States on a valid visa; or
  6. 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.

– **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 enroll, request special enrollment, terminate coverage for yourself and/or your dependents, change your enrollment status, or update your life insurance beneficiary, go online to www.zenith-american.com. Select Enrollment, and then select Family Status Change. For more information, contact the Plan Office:

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

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.

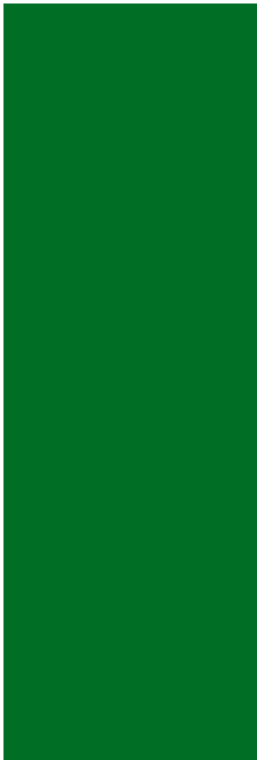
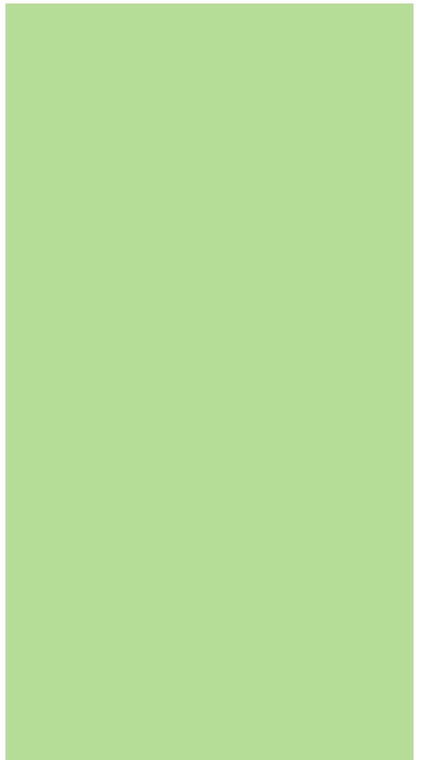
If you request to terminate coverage for yourself or your eligible dependent due to becoming eligible for other coverage, coverage under the Plan will end on the first day of the month following receipt of all requested information.

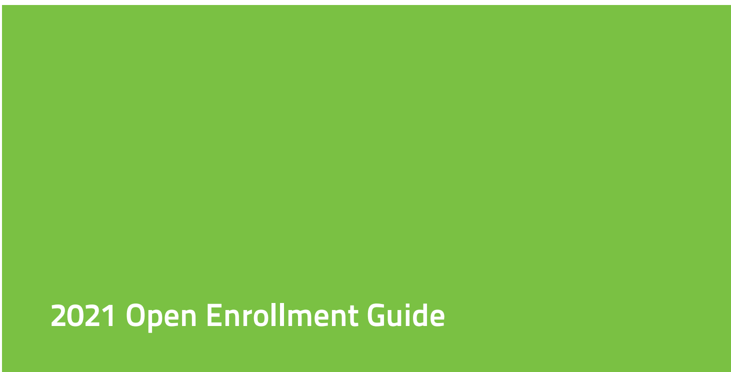
If you request to terminate coverage for your dependent due to the dependent no longer satisfying the definition of Dependent set forth in the Plan's Rules and Regulations, coverage for such dependent will end in accordance with the Plan's Rules and Regulations.

- **Working Spouse Weekly Co-Premium Payment.** The Plan will permit you to stop payment of the additional $23.08 per week co-premium 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-premium 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-premium payment 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.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