Rocky Mountain UFCW Unions & Employers

HEALTH BENEFIT PLAN

2021 Enrollment Guide for Newly Eligible Participants

Your Benefits Your Options Your Choice

Enroll today for coverage for yourself and your dependents.

EXPRESS LANE to Good Health

Rocky Mountain UFCW Unions & Employers Health Benefit Plan
Healthcare Management Program

Enrollment Guide for Newly Eligible Participants

Welcome to the Rocky Mountain UFCW Unions & Employers Health Benefit Plan! As a newly eligible participant in the Health Benefit Plan (the Plan), you have the opportunity to enroll yourself and any eligible dependents for Plan coverage for the balance of the current calendar year.

Enroll Today!

When you become eligible for coverage, you must enroll and authorize payroll deductions (if required under your collective bargaining agreement) by the deadline stated in the cover letter included with your enrollment materials to be covered under the Plan in the current calendar year. Any requested 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 by the deadline stated in the cover letter included with your enrollment materials.

If your spouse is eligible for coverage under this Plan as well as his or her employer's plan and elects not to enroll in his or her employer's plan, you are required to make an additional weekly contribution for his or 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).

ABOUT THIS GUIDE

This 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 Guide carefully. It is up to you to understand your benefits and how they work and to complete your enrollment by the deadline stated in the cover letter included with 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 UnitedHealthcare/UMR PPO Medical Plan or the Kaiser Permanente HMO Plan, you have to complete a Health Assessment to be eligible for a monthly co-premium reduction. Generally, you must complete the Health Assessment within 90 days of the completion of your enrollment to be eligible for a monthly co-premium reduction in the current calendar year. See page 4 for more information.

When enrolling, you must provide the Plan Office with dependent information, including their eligibility for other coverage, as well as your spouse's employment status and eligibility for employment-based health coverage, if applicable (see page 2).

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 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 10 of this Guide).

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.

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

- **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 UnitedHealthcare/UMR Choice Plus Network Provider or a Non-Network Provider. 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"). 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, 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. To find out if Kaiser is available where you live, go to **www.kp.org** or call 800-632-9700 or 303-338-3800. See page 2 for more information.

  In addition, please be advised that if you enroll in the Kaiser Permanente HMO Plan, your coverage under the HMO Plan will be effective the first day of the month **after** you complete your enrollment. You will be covered under the UnitedHealthcare/UMR PPO Plan during the period between when you become initially eligible under the Plan and the date your coverage under the Kaiser Permanente HMO Plan is effective. For example, if you become initially eligible under the Plan on February 1, 2021, and complete your enrollment electing coverage under the Kaiser Permanente HMO Plan on April 3, 2021, you will become eligible under the Kaiser Permanente HMO Plan effective May 1, 2021. Coverage for the period of February 1, 2021, through April 30, 2021, will be under the UnitedHealthcare/UMR PPO Medical Plan.

The Plan contracts with ESI, whose retail pharmacies (called "participating pharmacies") will fill your prescriptions at pre-negotiated rates. Participating network pharmacies include:

- Albertsons
- City Market
- King Soopers
- Safeway

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

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 Number	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, 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**
UnitedHealthcare/UMR 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 Plan 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**
Dental Benefits	Delta Dental	800-610-0201 *or* 303-741-9305	**www.deltadentalco.com**
Urgent Care at Home: DispatchHealth (If you live outside the areas noted, contact Kaiser Permanente or UnitedHealthcare/UMR to see 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: • Denver/Boulder: 720-738-9539 • Colorado Springs: 719-401-0147 • Longmont: 303-500-1518	**www.dispatchhealth.com**
Life or AD&D Insurance Benefits	Union Labor Life Insurance Company 8403 Colesville Road, 13th Floor Silver Spring, MD 20910	202-682-0900	**www.ullico.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)
- Enrollment information:
  - Enrollment Form
  - List of documents required for enrolling dependents
  - Spousal Verification Form
- A Notice of Privacy Practices
- A Notice of Prescription Drug Creditable Coverage
- A HIPAA Authorization for Release of Health Information
- An EEOC Wellness Program Notice
- 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.

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.

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, you must submit the required documents (see the list of documents required for enrolling dependents included in these materials). Please note, if you are enrolling your spouse, you must submit a completed Spousal Verification Form which is included with these enrollment materials. Only your dependents that meet the Plan's definition of eligible dependents may be enrolled. When you enroll an eligible dependent, you must indicate whether or not your dependent is eligible for other coverage (for example, if your dependent is eligible for coverage through his or her employer).

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 that child will be the next Open Enrollment period in the fall of the current calendar year, for coverage effective January 1 of the following year.

Take Advantage of UnitedHealthcare Premium Care Physicians

If you elect to have UnitedHealthcare/UMR PPO Medical Plan coverage, you can take advantage of UnitedHealthcare's Premium Care Physicians. Premium Care Physicians are doctors in the UnitedHealthcare Choice Plus network who meet or exceed specific quality and cost-efficiency standards in one of 16 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 Premium Care Physician** for covered services. This means that **your Co-payments will be lower** with a Premium Care Physician than with a specialist in the UnitedHealthcare Choice Plus network who is not a UnitedHealthcare Premium Care Physician.

You can find out which specialists are Premium Care Physicians at **www.umr.com** or by calling UnitedHealthcare/UMR at 800-826-9781.

Kaiser Permanente HMO Service Area

If you live or work in a Kaiser Permanente 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. 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, Colorado Springs, and Longmont service areas)

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

Participants in the Denver/Boulder, Colorado Springs, and Longmont service areas may request urgent care at home from 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
- Longmont: 303-500-1518
- **www.dispatchhealth.com**

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

Initial Eligibility for Plans A, B, and C

The Plan's initial eligibility requirements for Plans A, B, and C (except dental benefits) are described on pages 1–2 of your SPD, which is included in this packet.

If you're enrolled in Plan A or B medical coverage, you and your enrolled dependents are also eligible for dental coverage. Special eligibility rules apply to Plan C dental coverage. For more information, refer to page 31 of your SPD or contact the Fund Office.

TELEHEALTH SERVICES AVAILABLE 24/7

The Plan covers Network telehealth services for eligible participants and dependents who are enrolled in either the UnitedHealthcare/UMR PPO Medical Plan or the Kaiser Permanente HMO Plan. See the enclosed Benefits Summary and SBC for information regarding coverage of telehealth services. Through telehealth services, you can access the care you need for a wide range of minor conditions—including getting most medication prescriptions—by connecting with a board-certified doctor via video chat or phone 24 hours a day, 7 days a week, without needing to leave home. You can use the telehealth services for conditions such as:

- sore throat
- headache
- stomachache
- fever
- cold and flu
- allergies and rashes
- acne
- respiratory infections
- UTIs
- pinkeye
- sinus problems
- skin problems

Contact UnitedHealthcare/UMR or Kaiser Permanente for more information.

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

Active participants and spouses with 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.

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 the current calendar year. If you and your spouse both complete Health Assessments, generally within 90 days of the completion of your enrollment, you will receive a $10 monthly co-premium reduction in the current calendar year.

The Health Assessment is an important first step in understanding your health status. After completing the Health Assessment (which takes about 10 to 15 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.

Note: You can also complete a paper assessment if you elect UnitedHealthcare/UMR coverage, 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?

UnitedHealthcare/UMR Clinical Health Risk Assessment: Go to **www.umr.com** via your computer, mobile device, or by scanning the QR code to the left. Then, log in or register, and look for **Clinical Health Risk Assessment**..

Kaiser Permanente Total Health Assessment: Go to **www.kp.org** or scan the QR code to the left, 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.

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

HOW YOUR MEDICAL COVERAGE WORKS

Feature	UnitedHealthcare/UMR PPO	Kaiser Permanente HMO
Providers	You may go to any health care provider. However, when you use Non-Network Providers, you pay a higher percentage, 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	UnitedHealthcare Choice Plus Preferred Provider Network. 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 a participating pharmacy, call Express Scripts, Inc. at 844-863-5330.	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 benefits.	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) 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.	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.
Co-payments	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.	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.
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 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.**	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 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.** 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 you enroll dependents, please refer to the list of documents required for enrolling dependents.

During periods when you are eligible for benefits under the Plan and you are receiving wages from your employer, your co-premium 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 co-premiums 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.

Additional Working Spouse Co-Premium

If you enroll your spouse, you must complete a Spousal Verification Form (see the list of documents required for enrolling dependents). If your spouse is eligible for coverage under his or 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 or 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, 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:

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

- 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, 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.

INITIAL ENROLLMENT

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 the current calendar year, make your benefits decisions together, and then enroll. (See below for enrollment instructions.) You must enroll by the deadline stated in the cover letter included with your enrollment materials to be covered in the current calendar year, subject to your Special Enrollment Rights.

Waiving Coverage

If you wish to waive coverage for the current calendar year, 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

1. 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 the current calendar year, 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?

You must submit the documents required for each enrolled dependent in order to complete the enrollment of each dependent.

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.

- **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**

  If You Have Used the Online System Before

  Click on **Login to your account** at the top right of the home page. Select **Participant** as your Account Type, and enter your username and password. If you've logged in before and have forgotten your username or password, click on **Need help registering or logging in?** to set a new username and password.

If You Have NOT Used the Online System Before

If you have never used the system before, click on **Login to your account** at the top right of the home page.

- In the Account Type box, 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 below.

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 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 Enrollment Elections**

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

- **After Enrolling**

  Once you enroll, your elections are effective through December 31 of the current calendar year. If you do not enroll by the deadline stated in the cover letter included with these materials, you will waive coverage for the current calendar year. You will not be able to make any changes to your coverage or the dependents you cover until Open Enrollment in the fall of the current calendar year, for coverage effective January 1 of the following year, 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.

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 the deadline stated in the cover letter included with these materials. If you mail your enrollment form back to the Plan Office, it must be postmarked on or before midnight of the deadline date shown on the cover letter included with your enrollment 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 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 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.
      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, or 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 or within 30 days of a dependent's entry into the United States on a valid visa, or if you acquire a child(ren) through birth, adoption, or placement for adoption within 60 days.
      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.
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.
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:

◊ Loss of other coverage;
◊ Marriage;
◊ Birth;
◊ Adoption or placement for adoption;
◊ Dependent's entry into the United States on a valid visa; or
◊ 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 terminate coverage for yourself and/or your dependent(s), go online to **www.zenith-american.com**, select **Enrollment**, and then select **Family Status Change**.

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 termination of 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 termination of 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 or her employer; or
  - Your spouse no longer has coverage available through his or 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 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.

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

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

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.

2021 Enrollment Guide for Newly Eligible Participants
(11/2020)