

California Employers Alliance

Benefit Plans

Offered through the
United Industrial, Services Workers of America
Health & Welfare Trust

LOCAL 12

ABOUT CEA

The California Employers Alliance (CEA) was created by the United Industrial, Services Workers of America, NFIU, LIUNA, and AFL-CIO to allow the smaller employer to join the Union's Health & Welfare Trust and to take advantage of large group, fully insured health plans.

The CEA is able to offer enrollees a fully insured Health Net PPO, Health Net HMO, Kaiser HMO, Western Health Advantage HMO, Delta Dental HMO (DeltaCare), and Delta Dental PPO plans.

There are no additional fees to join. Monthly billing is provided by Musicians Benefit Administrators, a Third Party Administrator.

Trust participation does not provide the enrollees with representation by the Union. Also, the Union will not have access to the enrollment information of the local or the enrollees.

With the continuous premium increases seen in the small group market, the CEA is providing a viable option for California's small employers.

PARTICIPATION RULES FOR LOCALS

- Each local will be a separate billing entity.
- A minimum of 6 subscribers is needed to begin the plan for a local.
- Bills are due to Musicians Benefit Administrators by the 15th of the month PRIOR to coverage period.
- In order to maintain group status, each local must collect premium from its enrolled members and submit one check to Musicians Benefit Administrators.
- Due to current in force policies, Local 7 cannot offer Kaiser HMO and Local 47 cannot offer Health Net HMO/PPO.*

PARTICIPATION RULES FOR MEMBERS

- Must be a member of the Local
- Must make initial premium payment for first and last month's premiums
- Must make subsequent monthly payments to the Local by the 1st of the month PRIOR to coverage month (i.e., March premiums are due by March 1st)
- Late payers will be terminated effective 1st of the month following late payment (no exceptions)
- Premium checks are payable to Local and sent to Local directly.
- For medical enrollment, you must select one of the following plans: Health Net PPO, Health Net HMO, Kaiser HMO, or Western Health Advantage. If Health Net HMO or Western Health Advantage HMO is selected, enrollee must select a Primary Care Physician (PCP). PCPs can be found online at www.healthnet.com for Health Net and www.westernhealth.com for Western Health Advantage.
- Pre-existing Conditions:
 - HMO – all conditions are covered from the 1st day of coverage
 - PPO – Pre-Existing Conditions are NOT covered for the first 6 months unless you have had continuous coverage for 6 months prior to enrollment on CEA plan.
 - Health Net will require a certificate of creditable coverage as proof.
- For dental enrollment, you must select either Delta Dental HMO (DeltaCare) or Delta Dental PPO. If Delta Dental HMO (DeltaCare) is selected, enrollee must select a dental office. Dental providers can be found online at www.deltadentalins.com.

HOW TO ENROLL FOR MEMBERS

Submit the following items:

1. Signed CEA Participation Joiner Agreement
2. Completed Enrollment Form(s)
3. Check payable to Local for first and last month's premium

Musicians Benefit Administrators
Contact: Mark Cormany
949-975-1155

CALIFORNIA EMPLOYERS ALLIANCE

UISWA WELFARE BENEFITS TRUST FUND

And

BARGAINING UNIT AGENCY PARTICIPATION IN UISWA

PARTICIPANT JOINER AGREEMENT

PARTICIPANT'S NAME _____ DATE OF BIRTH _____

ADDRESS _____ PHONE _____ FAX _____ Email _____

CITY, STATE, ZIP CODE _____

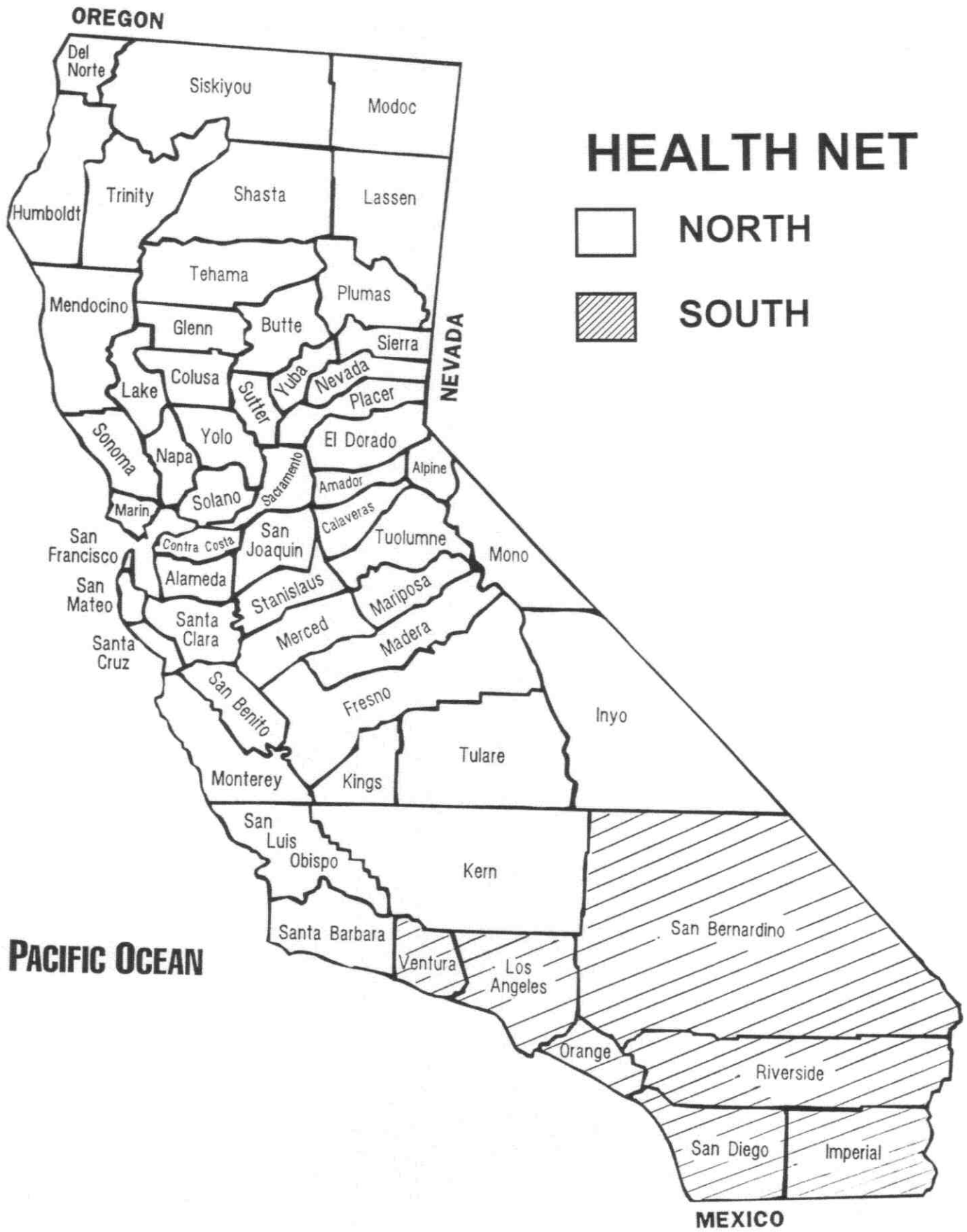
SINGLE _____ MARRIED _____ JOB TITLE _____ PLAN SPONSOR _____

I am applying for participation in the UISWA Welfare Benefits Trust Fund. I understand that participation in the Welfare Benefits Trust Fund requires membership in the UISWA established by an agreement between my Plan Sponsor and the UISWA.

I hereby give my Plan Sponsor authorization to deduct from my wages and transmit to UISWA, such amount as may be lawful and properly adopted in the current agreement as the agency fees. This authorization shall be irrevocable for the period of one year following the date it is signed or until the current agreement expires between the U.I.S.W.A. Trust and the C.E.A., whichever occurs first. This authorization shall automatically renew from year to year. If I cancel my participation in the Trust benefit offering, this authorization will also be considered as terminated.

PARTICIPANT: _____ DATE: _____

CEA/UISWA REPRESENTATIVE: _____ DATE: _____



HEALTH NET Rates - Local 12

	Health Net HMO		Health Net PPO	
	Southern CA	Northern CA	Southern CA	Northern CA
Monthly Premium 1/1/12-12/31/12				
Subscriber	\$724.50	\$909.50	\$811.50	\$1,062.50
Subscriber + 1	\$1,502.50	\$1,902.50	\$1,682.50	\$2,222.50
Subscriber + 2 or more	\$2,046.50	\$2,592.50	\$2,302.50	\$3,002.50
MEDICAL SERVICES			In Network	Out of Network
Deductible			\$1,500 / 3x family	
~ Calendar Year Deductible	Not Applicable			
Physician Services (Office Visits)				
~ Office Visits	\$30 Co-pay		\$20 Co-pay	40% Co-pay
~ Specialist Visits	\$60 Co-pay		\$20 Co-pay	40% Co-pay
~ Physical & Occupational Therapy	\$30 Co-pay		20% Co-pay	40% Co-pay
~ Lab & X-ray	No Charge		20% Co-pay	40% Co-pay
Maternity Care				
~ Prenatal & Postnatal Care	\$30 Co-pay		20% Co-pay	40% Co-pay
~ Normal Delivery	20% Co-pay		20% Co-pay	\$500/admit + 40% Co-pay
~ Complications (Includes C Sections)	20% Co-pay		20% Co-pay	40% Co-pay
Preventive Care				
~ Well Women Exam	\$30 Co-pay		\$20 Co-pay	Not Covered
~ Well Baby Care	\$30 Co-pay		\$20 Co-pay	Not Covered
~ Periodic Health Exam	\$30 Co-pay		\$20 Co-pay	Not Covered
Hospital Services				
~ Inpatient Care	20% Co-pay		20% Co-pay	\$500/admit + 40% Co-pay
~ Outpatient Care	20% Co-pay		20% Co-pay	\$500/surgery + 40% Co-pay
~ Complex Radiology (CT, MRI, PET)	\$200 Co-pay		20% Co-pay	40% Co-pay
~ Urgent Care	\$30 Co-pay		\$20 Co-pay	40% Co-pay
~ Emergency Care				
Ambulance	\$200 Co-pay		\$50 + 20% Co-pay	\$50 + 40% Co-pay
ER	\$200 Co-pay		\$100 + 20% Co-pay	\$100 + 40% Co-pay
If admitted	Waived		\$100 waived	\$100 waived
Psychiatric Services				
~ Inpatient Care (30 days/yr max)	20% Co-pay		20% Co-pay	\$500/admit +40% Co-pay
~ Outpatient Care - Crises Intervention	\$30 Co-pay		\$20 Co-pay	40% Co-pay
Alcohol/Chemical Dependency				
~ Inpatient Care (Detox Only)	20% Co-pay		20% Co-pay	20% Co-pay
~ Outpatient Care	\$30 Co-pay		20% Co-pay	40% Co-pay
Prescription Drugs				
~ Level I	\$10 Co-pay		\$10 Co-pay	\$10 + 50% Co-pay
~ Level II	\$25 Co-pay		\$35 Co-pay	\$35 + 50% Co-pay
~ Level III	\$50 Co-pay		\$50 Co-pay	\$50 + 50% Co-pay
~ Mail Order	90 day for 2x Co-pay		90 day for 2x Co-pay	Not Covered
Additional Benefits				
~ Durable Medical Equipment	No Charge (\$2k/yr max benefit)		20% (\$2k/yr max benefit)	40% (\$2k/yr max benefit)
~ Diabetic Supplies	No Charge		20% Co-pay	40% Co-pay
Out of Pocket Maximums				
~ One Member	\$3,500		\$3,000	\$6,000
~ Two Members	\$7,000		\$6,000	\$12,000
~ Family	\$7,000		\$9,000	\$18,000
Preexisting Conditions	Covered		Not Covered for 6 months without prior coverage	

This is only a summary of benefits. Please consult contract for complete descriptions of benefits, exclusions, and participating requirements.

MEMBER ENROLLMENT AND CHANGE FORM

(Sections 1, 2, 3, 4 and 8 are required.)

EMPLOYER NAME

COVERAGE EFFECTIVE DATE

EMPLOYER GROUP NUMBER (Medical)

SOCIAL SECURITY NUMBER

IMPORTANT: PLEASE PRINT ALL SECTIONS IN BLACK INK.

1 SELECTED COVERAGE

1a: CHECK THE DESIRED PLAN AS OFFERED BY YOUR EMPLOYER:

MEDICAL PLAN (write the plan number next to the product, if known)

- | | |
|--|---|
| <input type="checkbox"/> HMO _____ | <input type="checkbox"/> FLEX NET (Indemnity) _____ |
| <input type="checkbox"/> HMO HRA _____ | <input type="checkbox"/> PPO _____ |
| <input type="checkbox"/> HMO Silver Network _____ | <input type="checkbox"/> PPO HSA _____ |
| <input type="checkbox"/> HMO Variable Copay _____ | <input type="checkbox"/> Out-Of-State PPO (OOS PPO) _____ |
| <input type="checkbox"/> HMO y Más _____ | <input type="checkbox"/> SALUD con Health Net _____ |
| <input type="checkbox"/> ELECT SM Open Access (EOA) _____ | <input type="checkbox"/> SELECT (POS) _____ |
| <input type="checkbox"/> ELECT (POS) _____ | <input type="checkbox"/> SELECT 3-tier POS _____ |
| <input type="checkbox"/> EPO _____ | <input type="checkbox"/> Other _____ |

REASON FOR APPLICATION:

- New hire
 Open Enrollment
 Loss of prior coverage date _____
 COBRA effective date _____
 Qualifying event _____
 Qualifying event date _____
 Add dependent
 Qualifying event _____
 Qualifying event date _____

Complete sections 1b /1c only if Health Net will be your dental and/or vision provider.

1b: DENTAL PLAN (choose one)

(write the plan number next to the product)

- HMO _____
 PPO _____
 INDEMNITY _____

1c: VISION PLAN

(write the plan number next to the product)

- PPO _____

REASON FOR CHANGE:

- Plan change
 Change address/name
 Delete dependent(s)
 (list names in Section 3)
 Other _____

2 EMPLOYEE PERSONAL INFORMATION

Last Name		First Name		M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female
Residence Address			City	State	Zip
Date of Birth Mo/Day/Yr	Social Security #/Matricula ID#		Job Title		
Telephone No. () ()	Work Telephone No. () ()		Email Address		
Date of Hire / /	Job Class	Dept. no.	Employment Status <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner	

NOTE: If you are choosing to decline coverage, skip to Section 5.

Coverage Type <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D	Medicare Claim/HICN #	Participating Physician Group/PPG#	Primary Care Physician/PCP#
Physician Name (First, Last)			Is this your current M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID # (complete only if electing Health Net Dental)

For HMO y más or Salud con Health Net Members: If available, I would prefer to receive communication and plan information in Spanish.
 Yes No

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3 FAMILY INFORMATION Please list all eligible family members to be enrolled. (Attach additional sheets if necessary)

<input type="checkbox"/> Spouse	<input type="checkbox"/> M	Last Name	First Name	M.I.
<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> F			
Residence Address <input type="checkbox"/> Check here if same as employee		City	State	Zip
Date of Birth Mo/Day/Yr		Social Security #/Matricula ID #		
Coverage Type		Medicare Claim/HICN#	Participating Physician Group/PPG#	Primary Care Physician/PCP#
<input type="checkbox"/> Medical	<input type="checkbox"/> Medicare			
<input type="checkbox"/> Dental	<input type="checkbox"/> Part A <input type="checkbox"/> Part B			
<input type="checkbox"/> Vision	<input type="checkbox"/> Part D			
Physician Name (First, Last)			Is this your current M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID # (complete only if electing Health Net Dental)
<input type="checkbox"/> Son	<input type="checkbox"/> Daughter	Last Name	First Name	M.I.
Residence Address <input type="checkbox"/> Check here if same as employee		City	State	Zip
Date of Birth Mo/Day/Yr		Social Security #/Matricula ID #		
Coverage Type		Medicare Claim/HICN#	Overage Dependent Type	Participating Physician Group/PPG#
<input type="checkbox"/> Medical	<input type="checkbox"/> Medicare		<input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student	
<input type="checkbox"/> Dental	<input type="checkbox"/> Part A <input type="checkbox"/> Part B		<input type="checkbox"/> Over 50% support	
<input type="checkbox"/> Vision	<input type="checkbox"/> Part D			Primary Care Physician/PCP#
Physician Name (First, Last)			Is this your current M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID # (complete only if electing Health Net Dental)
<input type="checkbox"/> Son	<input type="checkbox"/> Daughter	Last Name	First Name	M.I.
Residence Address <input type="checkbox"/> Check here if same as employee		City	State	Zip
Date of Birth Mo/Day/Yr		Social Security #/Matricula ID #		
Coverage Type		Medicare Claim/HICN#	Overage Dependent Type	Participating Physician Group/PPG#
<input type="checkbox"/> Medical	<input type="checkbox"/> Medicare		<input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student	
<input type="checkbox"/> Dental	<input type="checkbox"/> Part A <input type="checkbox"/> Part B		<input type="checkbox"/> Over 50% support	
<input type="checkbox"/> Vision	<input type="checkbox"/> Part D			Primary Care Physician/PCP#
Physician Name (First, Last)			Is this your current M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID # (complete only if electing Health Net Dental)
<input type="checkbox"/> Son	<input type="checkbox"/> Daughter	Last Name	First Name	M.I.
Residence Address <input type="checkbox"/> Check here if same as employee		City	State	Zip
Date of Birth Mo/Day/Yr		Social Security #/Matricula ID #		
Coverage Type		Medicare Claim/HICN#	Overage Dependent Type	Participating Physician Group/PPG#
<input type="checkbox"/> Medical	<input type="checkbox"/> Medicare		<input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student	
<input type="checkbox"/> Dental	<input type="checkbox"/> Part A <input type="checkbox"/> Part B		<input type="checkbox"/> Over 50% support	
<input type="checkbox"/> Vision	<input type="checkbox"/> Part D			Primary Care Physician/PCP#
Physician Name (First, Last)			Is this your current M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID # (complete only if electing Health Net Dental)

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<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Last Name	First Name	M.I.
Residence Address <input type="checkbox"/> Check here if same as employee		City	State Zip
Date of Birth Mo/Day/Yr		Social Security #/Matricula ID #	
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Coverage Type Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D	Medicare Claim/HICN#	Overage Dependent Type <input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support
			Participating Physician Group/PPG#
			Primary Care Physician/PCP#
Physician Name (First, Last)		Is this your current M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID # (complete only if electing Health Net Dental)

4 DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE? IF YES, PLEASE COMPLETE THIS SECTION, INCLUDING MEDICARE (if applicable).

Please fill out the following information to receive proper credit for PREVIOUS COVERAGE, if immediately prior to becoming eligible for this plan, you or your dependents were covered under any public or private health care coverage (including MediCal or individual coverage). According to federal law, your employer or FORMER CARRIER must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.

<input type="checkbox"/> Self	Name	Name of Other Insurance Carrier	Prior Coverage Start Date Mo Day Yr
Prior Coverage End Date Mo Day Yr	Reason for Ending Coverage	Group #/Policy ID #	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No
			Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D
			Medicare Claim/HICN #
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Name	Name of Other Insurance Carrier	Prior Coverage Start Date Mo Day Yr
Prior Coverage End Date Mo Day Yr	Reason for Ending Coverage	Group #/Policy ID #	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No
			Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D
			Medicare Claim/HICN #
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Name	Name of Other Insurance Carrier	Prior Coverage Start Date Mo Day Yr
Prior Coverage End Date Mo Day Yr	Reason for Ending Coverage	Group #/Policy ID #	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No
			Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D
			Medicare Claim/HICN #
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Name	Name of Other Insurance Carrier	Prior Coverage Start Date Mo Day Yr
Prior Coverage End Date Mo Day Yr	Reason for Ending Coverage	Group #/Policy ID #	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No
			Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D
			Medicare Claim/HICN #
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Name	Name of Other Insurance Carrier	Prior Coverage Start Date Mo Day Yr
Prior Coverage End Date Mo Day Yr	Reason for Ending Coverage	Group #/Policy ID #	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No
			Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D
			Medicare Claim/HICN #

5 DECLINATION OF COVERAGE (complete this section if any coverage is to be declined by you or your eligible dependents.)

- Declining Medical coverage for:** **Reason:** Other group coverage through this employer Individual Coverage
 Name: _____ Other group coverage by another group (*i.e. spouse's employer*) Other _____
 Self Spouse Domestic Partner Dependent(s)
-
- Declining Dental coverage for:** **Reason:** Other group coverage through this employer Individual Coverage
 Name: _____ Other group coverage by another group (*i.e. spouse's employer*) Other _____
 Self Spouse Domestic Partner Dependent(s)
-
- Declining Vision coverage for:** **Reason:** Other group coverage through this employer Individual Coverage
 Name: _____ Other group coverage by another group (*i.e. spouse's employer*) Other _____
 Self Spouse Domestic Partner Dependent(s)

STOP AND READ CAREFULLY.

The available coverages have been explained to me by my employer. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s).
By declining coverage I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment period or qualifying event. Additionally, by signing below I certify that the reason I am declining coverage is accurate as indicated by the check marks above.

Employee Signature _____ Date _____

(SIGN ONLY IF DECLINING COVERAGE. IF SIGNED IN ERROR, PLEASE CROSS OUT AND INITIAL.)

6 ACCEPTANCE OF COVERAGE (signature required.)

THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I acknowledge and understand that health care providers may disclose health information about me or my dependents to Health Net Entities, the DBP Entities and/or Fidelity Entities. Health Net Entities, the DBP Entities and/or Fidelity Entities use and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs. Health Net's Notice of Privacy Practices is included in the evidence of coverage or certificate of insurance for coverage underwritten by Health Net Entities. I may also obtain a copy of this Notice on the website at www.healthnet.com or through the Health Net Customer Contact Center.

NOTICE: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

ACKNOWLEDGEMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from the Health Net Entities, the DBP Entities and/or the Fidelity Entities, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. I have read and understand the terms of this Application and my signature below indicates that the information entered in this Application is complete, true and correct, and I accept these terms.

BINDING ARBITRATION AGREEMENT: Subject to the terms of the Plan Contract or Insurance Policy (which may prohibit mandatory arbitration of certain disputes if the Plan Contract or Insurance Policy is subject to ERISA, 29 U.S.C. section 1001, et seq.), I, the Employee, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and the Health Net Entities, the DBP Entities and/or the Fidelity Entities, regarding the construction, interpretation, performance or breach of the Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net Entities, the DBP Entities and/or the Fidelity Entities membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Net Entities, the DBP Entities and/or the Fidelity Entities, are giving up their constitutional right to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with the Health Net Entities, the DBP Entities and/or the Fidelity Entities involving claims for medical malpractice are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I agree to submit any dispute to binding arbitration.

Employee Signature _____

Date _____

"Plan Contract" refers to the Health Net of California, Inc. and/or Dental Benefit Providers of California, Inc. Group Service Agreement and Evidence of Coverage; "Insurance Policy" refers to Health Net Life Insurance Company, Unimerica Insurance Company, and/or Fidelity Security Life Insurance Company Group Policy and Certificate of Insurance.



KAISER Rates - Local 12

	Kaiser HMO	
Monthly Premium effective 11/1/11	Southern CA	Northern CA
Subscriber	\$607.50	\$697.50
Subscriber + Spouse	\$1,282.50	\$1,477.50
Subscriber + Child(ren)	\$1,092.50	\$1,262.50
Subscriber + Family	\$1,992.50	\$2,302.50
MEDICAL SERVICES		
Deductible		
~ Calendar Year Deductible	Not Applicable	
Physician Services (Office Visits)		
~ Office Visits	\$40 Co-pay	
~ Specialist Visits	\$40 Co-pay	
~ Physical & Occupational Therapy	\$40 Co-pay	
~ Lab & X-ray	\$10 Co-pay	
Maternity Care		
~ Prenatal & Postnatal Care	\$10 Co-pay	
~ Normal Delivery	\$250 per admission	
~ Complications (Includes C Sections)	No Charge	
Preventive Care		
~ Well Women Exam	\$40 Co-pay	
~ Well Baby Care	\$10 Co-pay	
~ Periodic Health Exam	\$40 Co-pay	
Hospital Services		
~ Inpatient Care	\$250 per admission	
~ Outpatient Care	\$250 per procedure	
~ Emergency Care	\$150 Co-pay	
Ambulance	\$150 Co-pay	
ER	\$150 Co-pay	
If admitted	Waived	
Psychiatric Services		
~ Inpatient Care (30 days/yr max)	\$250 per admission	
~ Outpatient Care - Crises Intervention	\$40 Co-pay	
Alcohol/Chemical Dependency		
~ Inpatient Care (Detox Only)	\$250 per admission	
~ Outpatient Care	\$40 Co-pay	
Prescription Drugs		
~ Generic	\$15 for up to a 30 day supply	
~ Brand Name	\$30 for up to a 30 day supply	
Additional Benefits		
~ Durable Medical Equipment	50% Coinsurance	
Out of Pocket Maximums		
~ One Member	\$3,000	
~ Two Members or more	\$6,000	
Preexisting Conditions		
	Covered	

This is only a summary of benefits. Please consult contract for complete descriptions of benefits, exclusions, and participating requirements.

KAISER Medicare Rates - Local 12

	Kaiser HMO - Senior Advantage	
Monthly Premium effective 11/1/11 Medicare (ages 65+)	Southern CA \$222.50	Northern CA \$222.50
MEDICAL SERVICES		
Deductible		
~ Calendar Year Deductible	Not Applicable	
Physician Services (Office Visits)		
~ Office Visits	\$20 Co-pay	
~ Specialist Visits	\$20 Co-pay	
~ Eye Exams for Refraction	\$20 Co-pay	
~ Hearing Exams	\$20 Co-pay	
~ Physical & Occupational Therapy	\$20 Co-pay	
~ Lab & X-ray	No Charge	
Preventive Care		
~ Annual Wellness Visit	No Charge	
Hospital Services		
~ Inpatient Care	No Charge	
~ Outpatient Care	\$20 Co-pay	
~ Urgent Care	\$20 Co-pay	
~ Emergency Care	No Charge	
Ambulance	No Charge	
ER	\$20 Co-pay	
If admitted	Waived	
Psychiatric Services		
~ Inpatient Care	No Charge	
~ Outpatient Care - Crises Intervention	\$20 Co-pay	
Alcohol/Chemical Dependency		
~ Inpatient Care (Detox Only)	No Charge	
~ Outpatient Care	\$20 Co-pay	
Prescription Drugs		
~ Formulary	\$10 for up to 100 day supply	
Additional Benefits		
~ Durable Medical Equipment	No Charge	
~ Eyewear purchased at Plan Medical Office	\$150 allowance per 24 months	
Out of Pocket Maximums		
~ One Member	\$1,500	
~ Two Members or more	\$3,000	
Preexisting Conditions		
	Covered	

This is only a summary of benefits. Please consult contract for complete descriptions of benefits, exclusions, and participating requirements.

California Region Group Enrollment/Change Form

Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.

TO BE COMPLETED BY EMPLOYER

Company name		Hire date (mm/dd/yyyy)
Group number	Enrollment unit	Effective enrollment/ change date (mm/dd/yyyy)

A. ENROLLMENT/CHANGE REASON (see Change Table for assistance) New group: Yes No

New Hire (complete sections A, B, C, D) Open Enrollment (complete sections A, B, C, D)
 Health Plan (Check one) HMO Plan Deductible Plan Other _____
 Loss of Other Coverage (complete sections A, B, C, D) Other (please specify) _____
 Name change (complete sections A, B, C, D) From: _____ To: _____
 Event Date (mm/dd/yyyy) _____

B. EMPLOYEE Have you ever been a Kaiser Permanente member? Yes No

Medical Record No. (if known) _____ Social Security No. _____
 Name (Last, First, MI) _____ Birth Date (mm/dd/yyyy) _____ Gender M F
 Home Address _____ City _____ State _____ ZIP _____
 Work Phone _____ Home Phone _____ E-mail _____
 Ethnicity _____ Preferred Language _____

C. FAMILY For additional dependents, attach a separate sheet with employee's name at top. (Last, First, MI)

<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner Gender <input type="checkbox"/> M <input type="checkbox"/> F Spouse/domestic partner name: _____ Former last name (if any): _____	Social Security No. _____ Birth Date (mm/dd/yyyy) _____ Medical Record No. _____
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student Gender <input type="checkbox"/> M <input type="checkbox"/> F Dependent name: _____ Relationship: _____	Social Security No. _____ Birth Date (mm/dd/yyyy) _____ Medical Record No. _____
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student Gender <input type="checkbox"/> M <input type="checkbox"/> F Dependent name: _____ Relationship: _____	Social Security No. _____ Birth Date (mm/dd/yyyy) _____ Medical Record No. _____
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student Gender <input type="checkbox"/> M <input type="checkbox"/> F Dependent name: _____ Relationship: _____	Social Security No. _____ Birth Date (mm/dd/yyyy) _____ Medical Record No. _____

Do any of dependents above live at another address? Yes No If yes, complete the following:

Name (Last, First, MI): _____ Address: _____

D. Kaiser Foundation Health Plan Arbitration Agreement: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Employee/Applicant signature	Date	Employer signature	Date
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*Additional documentation may be required.





Kaiser Permanente Senior Advantage (HMO) **ENROLLMENT FORM** Northern California Region or Southern California Region Group Plan

IMPORTANT INFO – Read *all* pages before signing this form

Complete and return this form to become a Kaiser Permanente Senior Advantage (HMO) member. If you and your spouse are both applying, you'll each need to complete a separate form. For help completing this form, call **1-800-443-0815** (TTY **1-800-777-1370**), seven days a week, 8 a.m. to 8 p.m.

- You're entering into an important agreement, governed by specific Medicare and Kaiser Permanente rules, explained further on. Your signature on this enrollment form signifies that you've read, understand, and agree to these provisions. Kaiser Permanente is a health plan with a Medicare contract.
- You must be enrolled in Medicare Part B. You must live inside our Senior Advantage service area to enroll. Check the ZIP codes/counties listed in the *Evidence of Coverage* to be sure you qualify for enrollment.
- If you have end-stage renal (kidney) disease (ESRD), you may not become a member of Senior Advantage unless one of the following is also true:
 - You were diagnosed with ESRD while you were already a Kaiser Permanente member in the Northern California region or the Southern California region, and you are enrolling during an allowable enrollment period. To be eligible, there must be no break in coverage between your current Kaiser Permanente coverage and the start of your coverage in our Senior Advantage plan.
 - You were in a Medicare Advantage (or Medicare+Choice) plan that left the Medicare program or stopped providing coverage in your area on or after December 31, 1998, and you have not yet used your one-time enrollment exception to enroll in a Medicare health plan.
 - You've had a successful kidney transplant and you attach a note or records from your doctor showing that you've had a kidney transplant and no longer need regular dialysis.
 - You belong to an employer group or union/trust fund plan who terminated their contract with another insurer and selected Kaiser Permanente as a plan option for their employees.

ABOUT THE ENROLLMENT PROCESS - Submitting your form

- After completing pages 1-3, read the sections titled "Release of Information" and "Conditions of Enrollment" at the end of this form. Then sign and date page 3.
- Keep the bottom white copy of this form. If required, send the middle yellow copy to your employer group or union/trust fund. Return the top, signed white copy in the enclosed postage-paid envelope to:
 - We'll review your form for completeness and required signatures and then contact you by mail that we have received it.
 - We'll notify Medicare that you've applied to join Senior Advantage.
 - Within 10 calendar days after Medicare confirms your eligibility, we'll confirm the effective date of your coverage. We'll send you a Kaiser Permanente ID card and information for new members.

Kaiser Permanente – Medicare Unit
P.O. Box 232400
San Diego, CA 92193-2400

COMPLETE THE REQUIRED FIELDS BELOW


Last Name	First Name	Middle Initial	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Permanent residence street address (Street Address ONLY – No P.O. Box)			Apt #
County	City	State	ZIP
Mailing address (if different from permanent residence)			Apt #
County	City	State	ZIP
Daytime phone number	Evening phone number		Date of Birth
Providing the following information is optional:			
E-mail address			
Other contact: Name		Phone number	

MEDICARE HEALTH INSURANCE CARD (REQUIRED INFO)

Complete this sample Medicare Health Insurance card with the information found on your own Medicare card. Copy each line exactly as it appears.

If you prefer, you may include a photocopy of your Medicare verification letter (Letter of Award from Social Security or the Railroad Retirement Board) that provides the same information.

You must have Medicare Part B to join a Medicare Advantage plan.

MEDICARE			HEALTH INSURANCE	
SAMPLE ONLY				
Name: _____				
Medicare Claim Number			Sex _____	
_____ - _____ - _____				
Is Entitled To			Effective Date	
HOSPITAL (Part A)			_____	
MEDICAL (Part B)			_____	

Last Name: _____ First Name: _____

ADDITIONAL REQUIRED INFORMATION

1. Are you a current or former member of any Kaiser Permanente health plan? Yes No
 If yes: Current Former Kaiser Permanente Medical Record Number _____

2. Do you currently have end-stage renal (kidney) disease? Yes No
 If yes, provide: Diagnosis date (mm/dd/yyyy) ____ / ____ / ____
 Transplant date ____ / ____ / ____

See the section titled "Important info" on the cover page for more information about enrolling with ESRD.

3. Are you a resident in a long-term care facility, such as a nursing home? Yes No
 If yes, provide: Date of admission ____ / ____ / ____
 Name of institution _____ Phone _____
 Address _____ City _____ State ____ ZIP _____

4a. Are you actively working for an employer with 20 or more employees who provides employee group health insurance coverage for you? Yes No
 If no, are you retired? Yes Retirement date ____ / ____ / ____

4b. Is your spouse actively working for an employer with 20 or more employees who provides employee group health insurance for you? Yes No
 If yes, provide name of spouse's employer _____

5. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, Workers' Compensation, VA benefits, or state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Senior Advantage? Yes No
 If yes, list other coverage and ID number(s) for this coverage:
 Name of other coverage _____
 ID# for this coverage _____ Group # for this coverage _____

Check here if you prefer to receive info in Spanish

This information is available in a different format or in Spanish by calling **1-800-443-0815** (TTY **1-800-777-1370**), seven days a week, 8 a.m. to 8 p.m.

Puede obtener esta información en un formato diferente o en español llamando al **1-800-443-0815** (TTY **1-800-777-1370**), los siete días de la semana, de 8 a.m. a 8 p.m.

If you currently have Kaiser Permanente coverage through more than one employer or union/trust fund, you must choose one coverage option for your Senior Advantage plan and complete the information below.

Employer Group/Union/Trust Fund Name _____

Employer Group/Union/Trust Fund ID# _____ Subgroup _____

Requested effective date (subject to CMS approval) ____ / ____ / ____

Last Name: _____ First Name: _____

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 1560.503-1), certain benefit-related disputes), any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

RELEASE OF INFORMATION

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Kaiser Permanente will release my information, including any prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

READ "CONDITIONS OF ENROLLMENT" BEFORE SIGNING AND DATING BELOW (REQUIRED INFO)

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this enrollment form means that I have read and understand the contents of this enrollment form. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment; and 2) documentation of this authority is available upon request by Kaiser Permanente or by Medicare.

Signature of applicant or
signature of authorized representative _____ Date ____ / ____ / ____

Authorized representative name _____ Relationship _____
(please print)

Address _____ Phone _____

Signature of any person who
assisted in completing this form _____ Date ____ / ____ / ____

INTERNAL USE ONLY

Date _____ Lang Pref _____

Rep _____ IEP ICEP AEP SEP

CONDITIONS OF ENROLLMENT – By completing this form, I agree to the following:

1. I will read the Senior Advantage *Evidence of Coverage (EOC)* when I get it to know which rules I must follow in order to get coverage in this Medicare Advantage plan. If I don't receive a copy of the *EOC*, I may call Kaiser Permanente at **1-800-443-0815** (TTY **1-800-777-1370**), seven days a week, 8 a.m. to 8 p.m.
2. I understand that Kaiser Permanente is a health plan with a Medicare contract.
3. I must maintain my enrollment in Medicare Part B.
4. I can be in only one Medicare Advantage plan or Medicare Advantage Prescription Drug Plan at a time. By enrolling in Senior Advantage, I will automatically be disenrolled from any other Medicare Advantage plan or Prescription Drug Plan in which I am currently a member.
5. If I currently have Kaiser Permanente coverage through more than one employer or union/trust fund, I must choose one of these coverage options for my Senior Advantage plan because I can be enrolled in only one Senior Advantage plan at a time. My other employer or union/trust fund may allow me to enroll in one of their non-Medicare plans as well. I will contact the benefit administrators at each of my employers or trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or trust fund's plan to select for my Senior Advantage plan.
6. It's my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
7. I understand that if I do not have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.
8. I understand that I must enroll in the Senior Advantage service area in which I reside. I understand that it's my obligation to notify Kaiser Permanente if I permanently move or leave the service area for more than six months in a row.
9. I may leave this plan at any time by sending a request to Kaiser Permanente or by calling **1-800-MEDICARE (1-800-633-4227** or TTY **1-877-486-2048**), 24 hours a day / 7 days a week. However, before I request disenrollment, I will check with my group or union/trust fund to determine if I am able to continue my group membership.
10. I understand that starting on the effective date of my coverage, I must receive all of my covered health care from Kaiser Permanente, except for emergency care, out-of-area urgent care when our network is not available, dialysis care while temporarily outside the service area, or authorized referrals. If I obtain routine care from non-Plan providers, neither Kaiser Permanente nor Medicare will be responsible for the costs. I will refer to the Senior Advantage *EOC* for more information about covered benefits and services. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border. Services authorized by Kaiser Permanente and other services contained in my Kaiser Permanente Senior Advantage *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR KAISER PERMANENTE WILL PAY FOR THE SERVICES.**
11. Once I become a member of Senior Advantage, I have the right to appeal plan decisions about payment/services.
12. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Kaiser Permanente, he/she may be paid based on my enrollment in Kaiser Permanente.
13. Counseling services may be available in my state to provide advice concerning Medicare supplemental insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.
14. If I am a Kaiser Permanente Medicare Cost member enrolling in Senior Advantage, I understand that the Medicare Cost plan is closed to new enrollment and I cannot re-enroll.

If you currently have health coverage from an employer or union/trust fund, joining Senior Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Senior Advantage. Read the communications your employer or union/trust fund sends you. If you have questions, visit their website or contact the office listed in their communications. If there isn't any info on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read carefully before you sign this form.

Western Health Advantage Network*

Hospitals/Emergency Rooms

Mercy General Hospital	Sacramento, CA
Mercy San Juan Hospital	Carmichael, CA
NorthBay Medical Center	Fairfield, CA
UC Davis Medical Center	Sacramento, CA
Mercy Hospital of Folsom	Folsom, CA
Methodist Hospital of Sacramento	Sacramento, CA
NorthBay VacaValley Hospital	Vacaville, CA
Woodland Memorial Hospital	Woodland, CA

Top Quality Providers Include (but not limited to):

Mercy Healthcare Sacramento
UC Davis Health System
NorthBay Healthcare
Woodland Healthcare
Hill Physicians Medical Group
Golden State Physicians Medical Group

*Network data is current as of 11/3/09 and subject to change.

Western Health Advantage Month Premiums
Rates Effective 2/1/2012 - 1/31/2013

Plan Advantage 40

	Member Only	Member + Spouse	Member + Child(ren)	Family
Under 30	\$316.00	\$626.00	\$711.00	\$1,031.00
30-39	\$356.00	\$716.00	\$771.00	\$1,186.00
40-49	\$411.00	\$846.00	\$801.00	\$1,271.00
50-54	\$541.00	\$1,041.00	\$931.00	\$1,401.00
55-59	\$646.00	\$1,221.00	\$1,046.00	\$1,536.00
60-64	\$776.00	\$1,481.00	\$1,221.00	\$1,801.00

Plan Premier 20

	Member Only	Member + Spouse	Member + Child(ren)	Family
Under 30	\$401.00	\$806.00	\$916.00	\$1,341.00
30-39	\$451.00	\$926.00	\$991.00	\$1,541.00
40-49	\$526.00	\$1,101.00	\$1,036.00	\$1,651.00
50-54	\$701.00	\$1,351.00	\$1,206.00	\$1,826.00
55-59	\$836.00	\$1,591.00	\$1,361.00	\$2,001.00
60-64	\$1,006.00	\$1,931.00	\$1,591.00	\$2,351.00

If a birthday occurring during the plan year would cause a member to move to the next higher age band, Western Health Advantage only requires that member be moved to the next age band at the plan anniversary (February 1) rather than the month of their birthday.

Western Health Advantage Benefits - Local 12

	Western Health Advantage Advantage 40	Western Health Advantage Premier 20
Monthly Premium Subscriber Subscriber + 1 Subscriber + 2 or more	See Age Rate Table	See Age Rate Table
MEDICAL SERVICES		
Deductible ~ Calendar Year Deductible	None	None
Physician Services (Office Visits) ~ Office Visits ~ Specialist Visits ~ Physical & Occupational Therapy ~ Lab & X-ray	\$40 Co-pay \$40 Co-pay \$40 Co-pay No Charge	\$20 Co-pay \$20 Co-pay \$20 Co-pay No Charge
Maternity Care ~ Prenatal & Postnatal Care ~ Normal Delivery ~ Complications (Includes C Sections)	No Charge 30% Co-pay 30% Co-pay	No Charge No Charge No Charge
Preventive Care ~ Well Women Exam ~ Well Baby Care ~ Periodic Health Exam	\$40 Co-pay No Charge \$40 Co-pay	\$20 Co-pay No Charge \$20 Co-pay
Hospital Services ~ Inpatient Care ~ Outpatient Care ~ Urgent Care ~ Emergency Care Ambulance ER If admitted	30% Co-pay 30% Co-pay \$50 Co-pay No Charge \$100 Co-pay Waived	No Charge \$100 Co-pay \$35 Co-pay No Charge \$100 Co-pay Waived
Psychiatric Services ~ Inpatient Care (30 days/yr max) ~ Outpatient Care - Crises Intervention Alcohol/Chemical Dependency ~ Inpatient Care (Detox Only) ~ Outpatient Care	30% Co-pay \$40 / 20 visits 30% Co-pay \$40 / 20 visits	No Charge \$20 / 20 visits No Charge \$20 / 20 visits
Prescription Drugs ~ Level I ~ Level II ~ Level III ~ Mail Order	\$10 Co-pay \$30 Co-pay \$50 Co-pay 90 day for 2x Co-pay	\$10 Co-pay \$20 Co-pay \$30 Co-pay 90 day for 2x Co-pay
Additional Benefits ~ Durable Medical Equipment ~ Diabetic Supplies	20% Co-pay Covered	20% Co-pay Covered
Out of Pocket Maximums ~ One Member ~ Two Members ~ Family	\$3,000 \$5,000 \$5,000	\$1,500 \$2,500 \$2,500
Preexisting Conditions	Covered	Covered

This is only a summary of benefits. Please consult contract for complete descriptions of benefits, exclusions, and participating requirements.



Enrollment/Change Form

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AS A CONDITION OF OBTAINING HEALTH COVERAGE.

ENROLLMENT

<input type="checkbox"/> New group	<input type="checkbox"/> Open enrollment
<input type="checkbox"/> New hire — date of hire: _____	
<input type="checkbox"/> Newly eligible — reason: _____	
<input type="checkbox"/> COBRA — effective date: _____	

Directions: Complete entire form. Select a Primary Care Physician (PCP) for yourself and each family member from the Provider Directory (or online at westernhealth.com) by writing his/her name and ID number in the appropriate areas below. **If you do not select a PCP, one will be assigned to you. Bolded boxes are required fields and must be completed.**

CHANGE

<input type="checkbox"/> Add dependent *
<input type="checkbox"/> Add newborn/newly adopted child *
<input type="checkbox"/> Remove dependent — effective: _____
<input type="checkbox"/> Change of name
<input type="checkbox"/> Change of address
<input type="checkbox"/> Change of PCP (will be effective first of the month following request)
* Date of qualifying event (if outside open enrollment): _____

Directions: Complete **only the first section of bolded boxes** (including your name, SS#, gender and date of birth) and any sections applicable to the change you are making.

PLAN INFORMATION

Benefit plan
Effective date
Group no.
Class
Subgroup

SECTION I — MEMBER INFORMATION

Employee name: First			Employer	
Last		MI		
SS#	Date of birth	Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female

Physical address (required)	City	ST	Zip
Mailing address (if different)	City	ST	Zip
Email address	Job title		
Home phone ()	Work phone ()	Existing patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
PCP name	Medical group	PCP ID#	
Racial identity	<input type="checkbox"/> White/Caucasian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____		
Ethnic identity	<input type="checkbox"/> Of Hispanic or Latino origin <input type="checkbox"/> Not of Hispanic or Latino origin		
Primary language spoken	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Chinese <input type="checkbox"/> Tagalog <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____		
Primary language written	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Chinese <input type="checkbox"/> Tagalog <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____		

2349 Gateway Oaks Drive
Suite 100
Sacramento, CA 95833

916.563.2250 or
888.563.2250

Visit our website for
more information at:
westernhealth.com

SECTION II — DEPENDENT INFORMATION

<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	SS#
Name: First		Last MI
Date of birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP name
Existing patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical group	PCP ID#
Racial identity	<input type="checkbox"/> White/Caucasian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____	
Ethnic identity	<input type="checkbox"/> Of Hispanic or Latino origin <input type="checkbox"/> Not of Hispanic or Latino origin	
Primary language spoken	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Chinese <input type="checkbox"/> Tagalog <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____	
Primary language written	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Chinese <input type="checkbox"/> Tagalog <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____	

<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Child <input type="checkbox"/> Full-time student over the age of 19	SS#
<input type="checkbox"/> Disabled (must meet criteria and provide proof of disability)		Relationship
Name: First		Last MI
Date of birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP name
Existing patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical group	PCP ID#
Racial identity	<input type="checkbox"/> White/Caucasian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____	
Ethnic identity	<input type="checkbox"/> Of Hispanic or Latino origin <input type="checkbox"/> Not of Hispanic or Latino origin	
Primary language spoken	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Chinese <input type="checkbox"/> Tagalog <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____	
Primary language written	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Chinese <input type="checkbox"/> Tagalog <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____	



Enrollment/Change Form

Employee name

<input type="checkbox"/> Add	<input type="checkbox"/> Child	<input type="checkbox"/> Full-time student over the age of 19	SS#
<input type="checkbox"/> Remove	<input type="checkbox"/> Disabled (must meet criteria and provide proof of disability)		Relationship
Name: First		Last	MI
Date of birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP name	
Existing patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical group		PCP ID#
Racial identity	<input type="checkbox"/> White/Caucasian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____		
Ethnic identity	<input type="checkbox"/> Of Hispanic or Latino origin <input type="checkbox"/> Not of Hispanic or Latino origin		
Primary language spoken	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Chinese <input type="checkbox"/> Tagalog <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____		
Primary language written	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Chinese <input type="checkbox"/> Tagalog <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____		

2349 Gateway Oaks Drive
Suite 100
Sacramento, CA 95833

916.563.2250 or
888.563.2250

Visit our website for
more information at:
westernhealth.com

Use additional forms if necessary to provide information for all dependents.

SECTION III — OTHER HEALTH COVERAGE INFORMATION

Are any of the enrollees listed in Section II eligible for Medicare? If yes, you must complete this section.

Name(s) of insured	Medicare Health Insurance Claim Number (HIC#)
Check all that apply: <input type="checkbox"/> Age 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD (End Stage Renal Disease)	

Name(s) of insured	Medicare Health Insurance Claim Number (HIC#)
Check all that apply: <input type="checkbox"/> Age 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD (End Stage Renal Disease)	

Do any of the enrollees listed in Section II have other health coverage? If yes, please complete this section.

Name(s) of insured	Insurance company	<input type="checkbox"/> Primary
Subscriber of coverage	Policy number	Effective date
		<input type="checkbox"/> Secondary

Name(s) of insured	Insurance company	<input type="checkbox"/> Primary
Subscriber of coverage	Policy number	Effective date
		<input type="checkbox"/> Secondary

SECTION IV — SIGNATURE REQUIRED

By signing below, I acknowledge that I have read, understand and agree to the terms and arbitration agreement stated below. A reproduction of this form shall be valid as an original.

- A. On behalf of myself and my eligible Dependents, I hereby apply for health care services coverage offered by Western Health Advantage (WHA) through my Employer, and agree to be bound by the WHA Group Service Agreement, Evidence of Coverage and Disclosure Form, and this Enrollment/Change Form.
- B. **ARBITRATION AGREEMENT: I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (INCLUDING ANY HEIRS OR ASSIGNS) AND WESTERN HEALTH ADVANTAGE, INCLUDING CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR SMALL CLAIMS COURT CASES AND CLAIMS SUBJECT TO ERISA, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE PARTIES, INCLUDING ANY HEIRS OR ASSIGNS, TO THIS ARBITRATION AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.**

Employee signature: _____ Date: _____

To the best of my knowledge the information contained herein is true and accurate. I hereby attest that employees and dependents submitted to WHA for coverage meet all eligibility requirements set forth in the Group Service Agreement between WHA and the employer group.

Employer signature: _____ Date: _____

DELTA DENTAL - Local 12

	DHMO DELTACARE		DPPO	
	IN NETWORK	IN NETWORK	OUT OF NETWORK	
Plan Name	Plan CA13B	PPO Plan		
Annual Maximum	None	\$1,000	\$1,000	
Deductible	None	\$50 / 3x family	\$75 / 3x family	
Waiting Period for Services	None	None	None	
<u>Preventive</u>				
210: X-rays, full mouth	No Charge	No Charge	You pay 20%	
1110: Teeth Cleaning	No Charge	No Charge	You pay 20%	
1203: Topical Fluoride (child)	No Charge	No Charge	You pay 20%	
<u>Restorative</u>				
2140: Amalgam filling - one tooth	No Charge	You pay 20%	You pay 20%	
2330: Resin based filling	No Charge	You pay 20%	You pay 20%	
<u>Endodontics</u>				
3310: Root canal - anterior	\$95	You pay 20%	You pay 20%	
3320: Root canal - bicuspid	\$185	You pay 20%	You pay 20%	
3330: Root canal - molar	\$335	You pay 20%	You pay 20%	
<u>Oral Surgery</u>				
7111: Extraction - coronal remnants	No Charge	You pay 20%	You pay 20%	
7210: Surgical removal of erupted tooth	\$45	You pay 20%	You pay 20%	
7240: Removal of impacted tooth	\$95	You pay 20%	You pay 20%	
<u>Major</u>				
2750: Crown procelin + precious metal	\$355	You pay 50%	You pay 50%	
2790: Crown full cast precious metal	\$355	You pay 50%	You pay 50%	
5110: Complete Denture (Lower or Upper)	\$285	You pay 50%	You pay 50%	
6000: Implants	Not Covered	You pay 50%	You pay 50%	
<u>Orthodontia</u>				
8080: Comprehensive Ortho Child (to age 19)	\$1,900	You pay 50%	You pay 50%	
8090: Comprehensive Ortho Adult	\$2,100	Not Covered	Not Covered	
MONTHLY RATES				
Rates Valid 12/1/11 - 11/30/2012				
Employee Only	\$24.00	\$66.00		
Employee + Spouse	\$36.00	\$116.00		
Employee + Child(ren)	\$39.00	\$131.00		
Family	\$51.00	\$191.00		

This is only a summary of benefits. Please consult contract for complete descriptions of benefits, exclusions, and participating requirements.



Enrollment — Voluntary

Group Name _____

Delta Group/Division Number _____

A ENROLLEE (Complete this section for new enrollment or change of status)

Name		Social Security Number _____ <small>(Member I.D. Number)</small>		Date Employed _____ Month / Day / Year		Action Requested <input type="checkbox"/> New enrollment <input type="checkbox"/> COBRA enrollment <input type="checkbox"/> Change in enrollment		Please enroll me in the following: <input type="checkbox"/> Reinstatement <input type="checkbox"/> Transfer <input type="checkbox"/> Rehire	
Last	First	Middle Initial	Do you have dependent children? <input type="checkbox"/> Yes <input type="checkbox"/> No			Employee Classification <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Hourly <input type="checkbox"/> Retired <input type="checkbox"/> COBRA			
Month	Day	Year	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Does your spouse have a dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, who is covered: <input type="checkbox"/> yourself <input type="checkbox"/> spouse <input type="checkbox"/> dependent children		
Birthdate			If Delta Dental, indicate group number: _____			FOR DELTA USE ONLY			
Mailing Address _____			Telephone Number _____			Effective Date of Coverage _____			
City _____			State _____			Family Indicator Code _____			
ZIP code _____			Qualifying Date _____			Effective date of change _____			

COBRA Enrollment

I understand that I may be required by the employer to pay for COBRA benefits

Note: If Dependent is enrolling under own social security number, the original Member's social security number must be supplied.

Benefits previously received under Social Security Number (Member I.D. Number) _____

B Change to Existing Enrollment (Complete all sections that apply)

Name change Add new dependent Delete dependent Address change listed above

Reason for change _____

Effective date of change _____
Month / Day / Year

C DEPENDENTS (Complete for new enrollment or to add or delete dependents)

Spouse Name Last (if different)	First	Middle Initial	Add/ Delete	Sex M F	Birthdate Month Day Year	Marriage/Divorce Date Month Day Year	Spouse's Social Security Number
Child Name Last (if different)	First	Middle Initial	Add/ Delete	Sex M F	Birthdate Month Day Year	<input type="checkbox"/> If Child is 19 years or older (check one) <input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled	Child's Social Security Number

D Signature (Form must be signed to be processed)

I understand that I may be required by the employer to pay for these benefits. I agree to continue membership in this program during employment and while the program is in force and I agree to comply with the terms of the group contract.

Enrollee Signature _____

Date _____

Group No. _____
 Contract Type _____
 Effective Date _____

Check One

- New Enrollment
- Name Change
- Facility Change*
- COBRA
- New Social Security Number/
Employee ID Number
- Address Change
- Add Dependent
- Remove Dependent

Indicate effective date of change:
 *(Does not pertain to facility change)

____ (Month) ____ (Day) ____ (Year)

Primary Enrollee Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: _____ (Last) _____ (First) _____ (M.I.)

Mailing Address: _____ (Street Address)

____ (City) _____ (State) _____ (Zip Code)

E-mail Address: _____

Date of Birth: _____ (Month) _____ (Day) _____ (Year) Male Female Home Phone #: (____) _____ - _____

Name of Employer/Group: _____

Location: _____

Soc. Security #: _____ - _____ - _____ Employee Identification #: _____

Contract Facility Name: _____ Contract Facility #: _____

COBRA Enrollment Only

Please indicate qualifying event:

- Termination
- Divorce
- Widowed
- Indication of Divorce
- Surviving Dependent
- Overage Dependent

Indicate qualifying date:

____ (Month) ____ (Day) ____ (Year)

Dependent Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (To add additional dependents, please attach a separate sheet.) Note: You may choose up to three separate offices for yourself and all dependent enrollees.

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

Relationship Code*	Dependent Name	Male/ Female (Check One) M F	Date of Birth (Month) (Day) (Year)	Contract Facility Name	Contract Facility #:
____	_____	<input type="checkbox"/> <input type="checkbox"/>	____ ____ ____	_____	_____
____	_____	<input type="checkbox"/> <input type="checkbox"/>	____ ____ ____	_____	_____
____	_____	<input type="checkbox"/> <input type="checkbox"/>	____ ____ ____	_____	_____
____	_____	<input type="checkbox"/> <input type="checkbox"/>	____ ____ ____	_____	_____
____	_____	<input type="checkbox"/> <input type="checkbox"/>	____ ____ ____	_____	_____
____	_____	<input type="checkbox"/> <input type="checkbox"/>	____ ____ ____	_____	_____
____	_____	<input type="checkbox"/> <input type="checkbox"/>	____ ____ ____	_____	_____

*Relationship Codes: Place the following two character code in the first column to designate each dependent as follows:

Spouse - SP Domestic Partner - DP Child - CH Child of DP - CD Other Adult - OA Other Child - OC

Signature of Primary Enrollee _____

Date _____